Diabetes Management System
User Manual

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System History...

Harbor Software was approached by several CDE's in 1995 who were looking for a way to track Diabetes Outcomes for the State's Department of Community Health. Over the next 15 years, the System evolved to meet the needs of CDE's with Outcomes Tracking, ADA Recognition, AADE DEAP Support Reporting, Charting, and all aspects of Data Management for a Diabetes Education Program. Harbor Software is continually working to improve and enhance the System to assist Diabetes Educators with their patient care.

System Overview...

The Diabetes Management System was designed with the input of Diabetes Educators in order to assist them with all aspects of their Education Programs. The major goals of the system are...

- Elimination of Redundant Data Entry.
- Simplify Record Keeping.
- Quantify Effectiveness of your Education Program.
- Measure Participant Knowledge Levels and their Understanding of Diabetes.
- Measure Outcomes.
- Effectively Track Participant Follow Ups.
- Track Participant Complication Rates.
- Maximize Reporting with Minimal Effort.
- Tracking Educator DSME and CE Hours.
- Assist in measuring ADA Criteria for Recognition and Annual Reporting.
- Assist with scheduling Staff and Patients.

Network Administrator Notes...

System Directory Structure

The Diabetes Management System installs in just two subdirectory folders. NO SYSTEM FILES, DLL's, OR DATA FILES ARE INSTALLED, NOR IS THE REGISTRY MODIFIED. The System was designed to be very simple to install, run, and maintain. The system is entirely self-contained within its subdirectory, including the database drivers. No other database drivers need to be installed, nor any ODBC connections need to be set up. The name of the system program subdirectory folder defaults to \DMS (which you can change at installation) and the data subdirectory folder is called DATA and is located directly underneath the program folder.

System Data Backup

All the DMS Data Files are in a subdirectory called DATA underneath the DMS program subdirectory (the default name is \DMS). ***REMEMBER, YOUR DATA IS VALUABLE AND IT IS YOUR RESPONSIBILITY TO DO, OR VERIFY, THAT SYSTEM-WIDE BACKUPS ARE DONE ON A FREQUENT AND REGULAR BASIS. BECAUSE THIS SYSTEM IS USED ON A WIDE VARIETY OF NETWORK PLATFORMS, THERE IS NO BUILT-IN BACKUP UTILITY IN THE DIABETES MANAGEMENT SYSTEM.***

System Requirements

The Diabetes Management System was designed with a small footprint and minimal requirements. It should run just fine on any existing hardware. The System will operate on any standard XP, Vista, Windows7 environment on a standard Windows Network, or as a stand-alone system. The system requires, ***AT A MINIMUM***, the following:

- Pentium 1 GHz CPU
- 1GB RAM (or more, depending on your network overhead)
- Approximately 60 MEG Disk Space and a MINIMUM storage space of approximately 0.3 Kb per participant record. This size requirement could change with future upgrades.

Installation Instructions

Network Notes…

If you are installing the Diabetes Management System onto a Network, please contact your Network Administrator **before proceeding** with installation.

Installing the System:

From a CD... Insert the Installation CD in your CD Drive and it should start automatically. If it does not, click on the START button (on your task bar) and select RUN. In the Open Dialog box, type in the CD Drive Letter that contains the installation CD followed by "SETUP" (ie, type "D:\SETUP"). Press or click on the OK button to begin the installation. Follow the prompts.

From a Download... Navigate to the download directory and run it. Follow the prompts. All the download installs are password protected. Be sure you have the password before you begin. Contact Harbor if you have questions.

After the installation, the Diabetes Management System Programs can be found in your Program Menu, as well as a shortcut icon on your desktop.

Installing Workstation Shortcuts:

The installation program installed a workstation installation program in the main program folder called WRKINST.EXE. This installation program automates the process of creating the necessary shortcuts on your workstation desktops. The network drive needs to be mapped prior to running this program.

Mapping Network Drives:

When you map the network drive to the workstation, do not set the DMS subdirectory so that it appears as the root directory on the workstation. This could cause a problem with the system's built-in automatic file upgrade utilities on some networks.

Directory Structure:

The default Diabetes Management System subdirectory defaults to \DMS located off of your root subdirectory. This may be different on your system, particularly if it was installed onto a network.

The system data subdirectory is called DATA and is located immediately underneath the DMS subdirectory, regardless of where it is installed.

Getting Familiar with the System...

System Security

HIPAA Requirements call for security measures to protect access to participant data. A user password is required to log in and access the System. There are three access levels the System; Administrator, Normal User, and Restricted User.

- *Administrator*- Unlimited Access to the System (typically, ALL licensed staff (RN's, RD's, CDE's, etc) should be set to the this level.
- *Normal User*- Access to all functions, EXCEPT: System Defaults, User Maintenance, Audit Modules, and Utilities Menu. The Normal User cannot update existing narrative notes.
- *Restricted User*- Access to patient information, VIEW ONLY, no update privileges.

Logging into the System

Whenever the System is started, a Log in Name and Password are required to be entered before proceeding. (The System is initialized with one Administrator Password.) The user has two chances to enter a correct Log in Name and Password. If unsuccessful, the system exits to the Operating System.

First Time Sign On

After installation, you will need to sign into the System as Administrator and assign passwords and access levels to all the users. This must be completed before the users can access the system. **The Initial Log In Last Name is: "ADMIN", Password is: "ADMIN"**, then click on the Log In button to sign in. Click on **FILE > USER MAINTENANCE** to load your users. For security purposes, you should delete the generic ADMIN sign on ID once you have your staff ID's loaded.

Maintaining Passwords

The System will display a reminder message to the user after log in if they have not changed their password within the last 60 days. There are two methods of changing a password…

1. The Administrator can change any user password in the **FILE | USER MAINTENANCE** Menu. Not only can they change passwords, they can add, delete, or modify any user in the System.
2. The User can change their own password by entering in their Name and Current Password, and clicking on the Change Password button. They will be requested to enter a new password, and then re-enter it again in order to verify accuracy. When completed, click on the Update Password button to complete the change and update the password. The user will be logged into the System. If the Log in button is clicked instead, they will be logged into the System, but their password remains unchanged.
3. **LOST PASSWORD?** Have someone with Administrator access log on to the System and go to **FILE | USER MAINTENANCE.** They need to delete your record and add it back in again with a new password (do not forget to enter in the appropriate access level).

File Activity Log

For added security, the system automatically tracks, records, and stores data changes on 3 major system files (participant's demographics, assessment data, narrative notes). Information stored includes date, time, user name, as well as capturing before and after images of the modified data.

SETTING UP THE SYSTEM

The DMS System requires the initialization of several files...

- Staff Profiles
- User Passwords (see System Security the prior page)
- Physician Information File
- System Defaults
- Class Sites
- Follow Up Status File
- Medication File
- Procedures File
- Behavioral Goals
- Default Goals (optional)
- Default Narrative Notes (optional)
- Default SOAP Notes (optional)
- County File (optional)

User Passwords

Click on **FILE > USER MAINTENANCE** to add, update, and delete user sign-on's. passwords, and user access levels. See prior section labeled "Maintaining Passwords" for more information.

Staff Profiles

Staff Profiles give you the ability to track personal and staff data. The following can be recorded for ADA Recognition...

- Licensure Information
- Hours and Responsibilities
- Education Plans
- CEU's
- DSME Experience

To access, click on **FILE > USER MAINTENANCE**. The Window displays your Staff on the left side of the window. The right side of the window displays the recorded CEU data for the highlighted staff member. To add a new Staff Member, click on the ADD button, click on the UPDATE button to modify an existing record. (See Also: Instructors at This Site and Educators DSME Experience Record under ADA 8th Edition Recognition).

Physician File

To set up the Physician File, click on **FILE > PHYSICIAN INFORMATION > PHYSICIAN MAINTENANCE**. The Look Up Window displayed can be sorted by Name or Physician Number by clicking on the appropriate tabs at the top of the window. To add a new physician, click on the ADD button. The Detail Information Window contains all the information on this physician's office. It is up to you to set up the physician numbers so it may be compatible with any current system. It is a good idea to set up an UNKNOWN physician if the referral isn't known (ie, #99999 is initially set up as an Unknown Physician).

Physician information can also be added and updated while patient demographics records are being added.

Utilities allows for the Importation of Physician Data (see the Utilities Menu for more information).

Check the inactive box if the physician is retired, deceased, or inactive. Labels and Mail Merge will not include an inactive Physician. A Physician Listing will print out an alphabetical list of Physicians, ID#, Institutions, City and office telephone number.

Class Sites

The System allows you to track participants that receive education from your site at various locations. The ADA recognizes this as an education program choosing to deliver their same program at different locations / addresses (the system can filter data/reports by location). If the main site is selected for a random on site audit, the required documentation must include documentation from each location.

To set up your Class Sites, click on **FILE > SYSTEM FILE MAINTENANCE > CLASS SITES.** To add a site, click on ADD, enter the data, and click on OK to save the data.

The option of Class Location is used whenever a participant or group are marked as attending a class.

Follow Up Status (Assessment Visit Types)

To set up Follow Up Status Codes and Descriptions, click **FILE > SYTEM FILE MAINTENANCE > FOLLOW UP STATUS**. These Status Codes are mandatory fields used in a patient's Assessment Record and are used to record and group the type of Assessment visits. There can be an unlimited number of Participant Status Codes, however it is best to limit them to a minimum. Please review and update them for your program BEFORE adding participant's assessments. To change Follow Up Status Codes in the system, highlight a follow up status code that will not be used and change to a more appropriate description. Activity Reports can be filtered by these Follow Up Status Codes.

Medication File

The Medication File is used to hold the patient medication history data, which can be quickly looked up and entered into the Participant Medication History. Also, many reports can be filtered by a Medication Name (or partial Medication Name) so just the patients with that medication will be printed or tallied.

To set up the Medication File, click **FILE > SYTEM FILE MAINTENANCE > MEDICATION FILE.** The Look Up Window displayed is sorted by Medication Name. To add a new Medication or update an existing one, click on the Add or Update button respectively. Enter in the Medication Name and click on Update to save it. The System installs with several common medications. It is up to the users to maintain this medication list.

County File

County of Residence can be tracked in a patient's demographic record. This is an optional field. To set up the County File, click **FILE > SYTEM FILE MAINTENANCE > COUNTY.** The Look Up Window displayed can be sorted by County Name or County Number by clicking on the appropriate tabs at the top of the window. To add a new county, click on the Insert button. The Detail Information Window contains all the information on this County. It is up to you to set up the county numbers so it may be compatible with any current system. It is a good idea to set up an UNKNOWN county if the referral isn't known (ie, use #999).

Procedures File

The Procedures File is used to hold different Procedure names that can be quickly searched and selected to print on the Progress Note. Note - The data in this procedures file are only used for the Progress Note Report (See Progress Note). To set up the Procedures File, click FILE > SYTEM FILE MAINTENANCE > PROCEDURE FILE. The Look Up Window displayed is sorted by Procedure Name. To Add a New Procedure or Update an Existing Procedure, click on the ADD or Update button respectively. Enter in the Procedure Name and an average length of time (this is optional) and click on Update to save the information.

System Defaults

The System Defaults window controls and maintains system-wide variables (ie, institution name and address). There is also information that can be set to automatically load when a new participant is added (ie, Default City, State, and Zip Code). Major Insurance Companies Information can be set here and is carried throughout the system. Margins for Letter/Chart Generator can be set (Inches from Top and Left), and Font Size (10, 11, 12).

Behavioral Goals

The behavioral Goals Data File is used to group goals into measurable behaviors (ie, AADE 7). Goal Outcomes can be tracked for individual participants as well as in group aggregates. To set up the Behavioral Goals File, click on **FILE > SYSTEM FILE MAINTENANCE > BEHAVIORAL GOALS**, then click add. These Goal Groups are used in the Goals Module, the Goals Outcome Report, and the Behavioral Goals Outcome Report.

Default Notes and Goals

Add standard stock narrative notes here, to be used in Assessment, Pathway (Narrative Notes), or Progress Notes. Add standard stock SOAP Notes here, to be used in Charting, Pathway (SOAP Notes). Maintain standard goals to be used in Patient goal statements, **Pathway > Goals > Add > Defaults.**

Looking Up Dates and Other Information

When an ellipsis button (…) is displayed, it indicates a look up window will be displayed by clicking on that ellipsis button. If it is a date, a monthly calendar will be displayed to select the date. Months can be advanced or decremented by clicking on the arrows in the top right and left of the calendar respectively. If you put a date into an area by mistake, click on the ellipsis button and use the zero out date option. If it is another look up field (ie, County, Physician, Hospital, etc.), the appropriate file will be displayed to easily select the right choice.

Participant Demographic Data.

Adding Demographic Data

To add a new participant record, click on PATIENTS button on the toolbar. A list of all participants in the system is displayed here. Click on the ADD button to add a new participant record. Each record has several tab pages that can be accessed by clicking on the appropriate tab at the top of the form. The only mandatory fields for each record are:

- Last and First Name
- Referring Physician Number

NOTE THAT THESE TWO FIELDS ARE THE ONLY ONES THAT ARE REQUIRED IN ORDER TO SAVE A RECORD. YOU DO NOT HAVE TO ENTER ALL THE OTHER DATA AT ONE TIME IN ORDER TO SAVE THIS PARTICIPANT'S DATA.

These mandatory fields are displayed in bold blue. Mandatory ADA fields are displayed in bold green.

To print a demographic report on a participant, highlight the Patient | Pathway | Face Sheet. A FACE SHEET will keep a running list of lab work from assessment. To **quickly scan for a participant,** type in the first three letters of their last name.

Using Agency/Group Identifier Code

Agency/Group Identifier Code is provided for your convenience to further filter the participant data. Found in the Demographic File under the General Tab, the Agency/Group Identifier Code can be used to divide patients by institution, other disease states, etc. For example one server may serve multiple institutions, to separate the data, Institution A can be Agency Code 1000, Institution B can be Code 2000, etc.

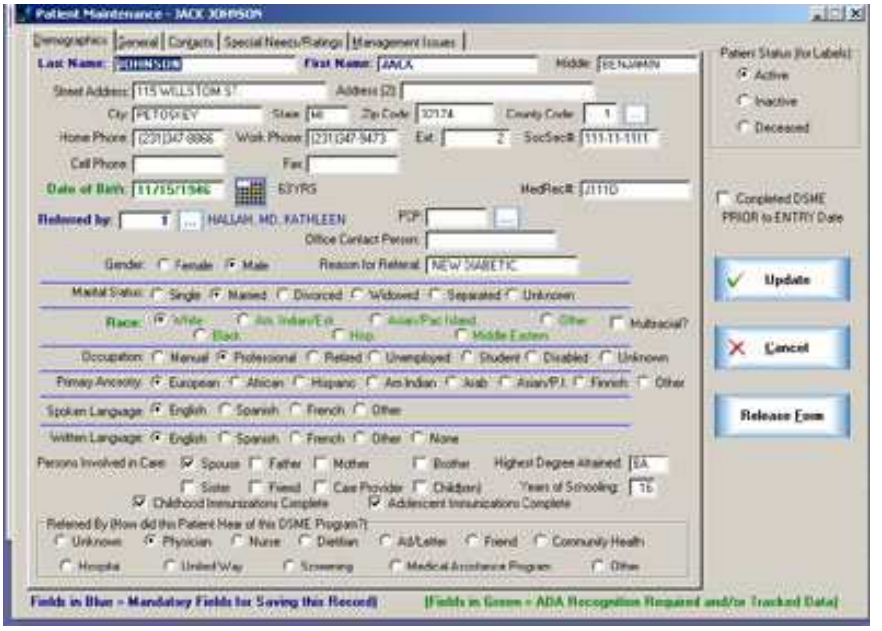


Fig. 1: Demographics Window (Demographics Tab)

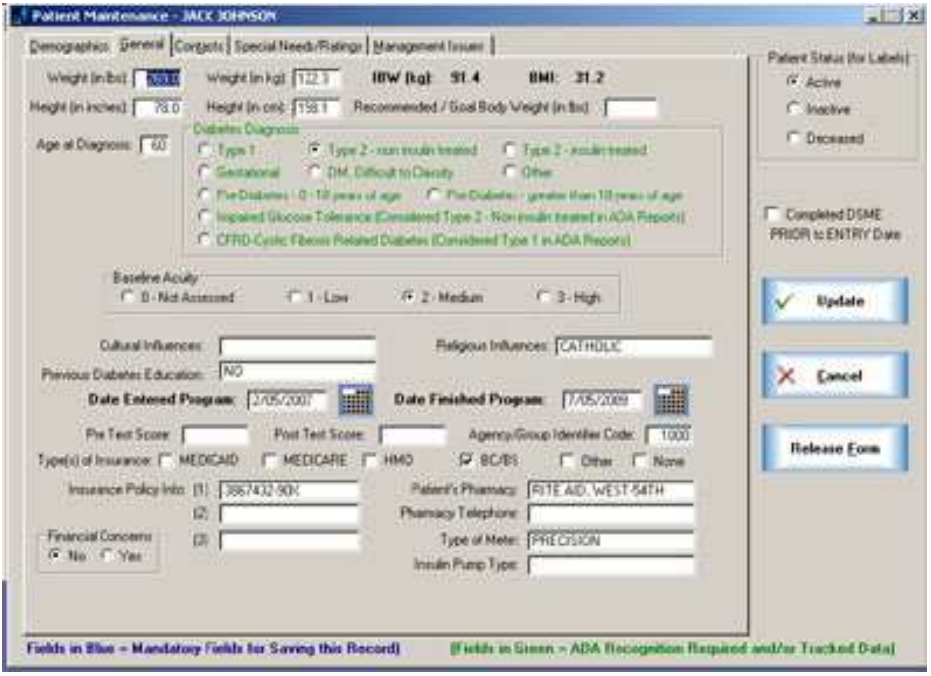


Fig. 2: Demographics Window (General Tab)

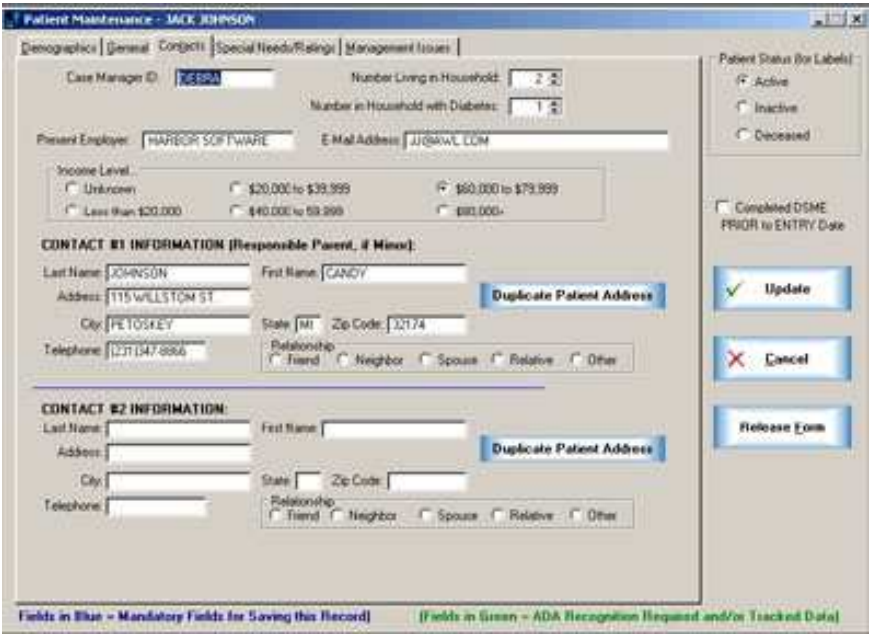


Fig. 3: Demographics Window (Contacts Tab)

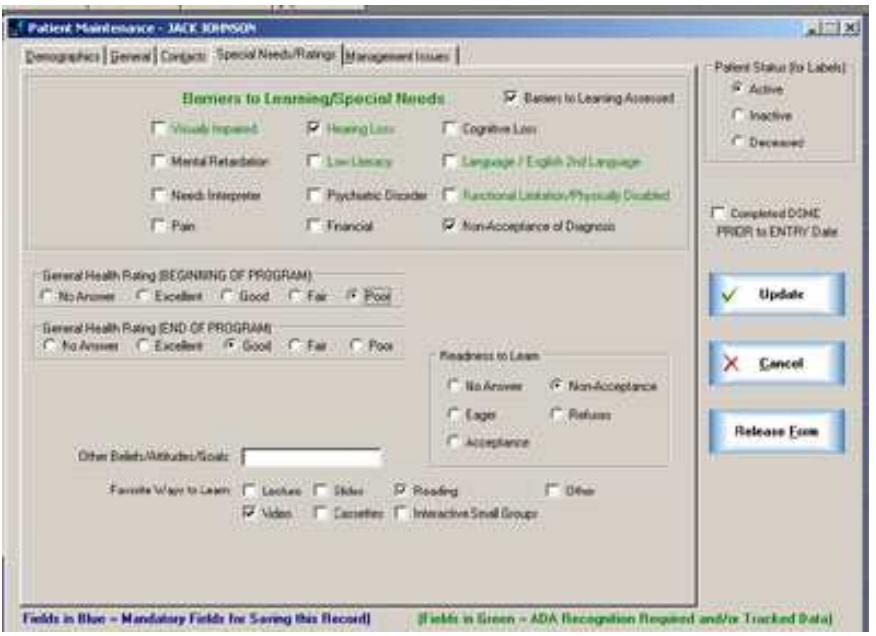


Fig. 4: Demographics Window (Special Needs/Ratings Tab)

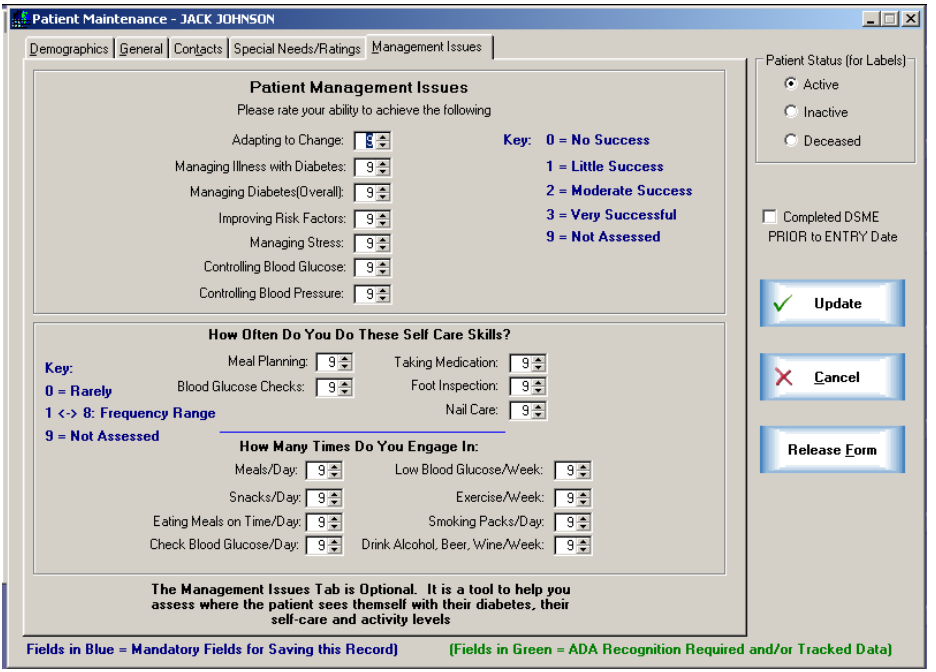


Fig. 5: Demographics Window (Management Issues Tab)

The Management Issues Tab is optional. It is simply a tool to help you assess where the patient sees them self with their diabetes, as well as their self-care and activity levels.

Patient E-Mail

You may store a participant's E-Mail address in the Demographic File under the Contacts Tab. To access their E-Mail just click on the address at the top of their Pathway. Your E-Mail program will automatically launch when you click on the displayed email.

Referral Out

To keep track of all participants referred out, why and when. Just highlight participant, click REFERRAL OUT then ADD. To get a report on referrals, Click on **REPORTS > REFERRALS**, and pick from one of five reports. REFERRAL TO SPECIALISTS report lists participants who were referred out, when, and why for any specified time period.

Patient Pathway

The Patient Pathway is a quick and easy way to access all parts of the patient's records. You can access the Pathway by highlighting the patient's name in the Lookup and clicking on the PATHWAY button. In version 5.2, a Patient Status Overview section was added on the Pathway Window in order to quickly see key indicators for this patient.

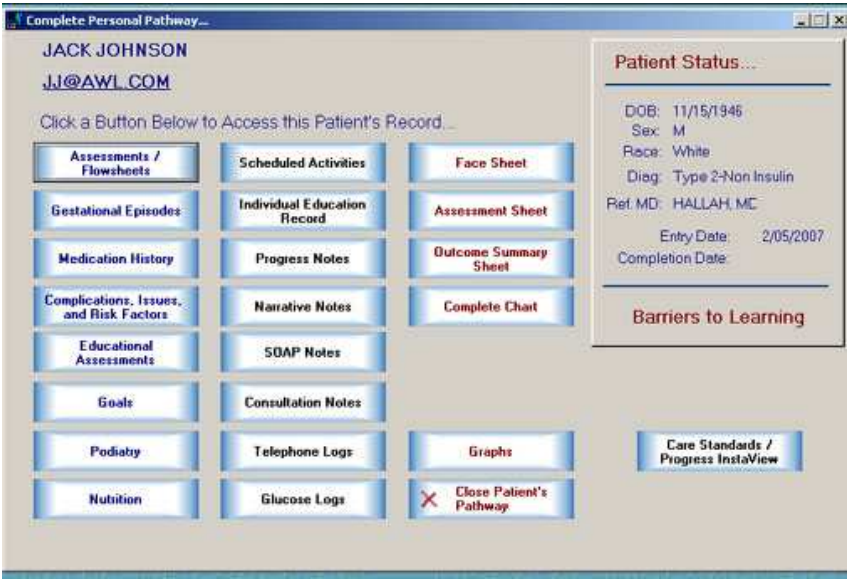


Fig. 6: The Pathway Window

Education Module

Comprehensive vs Post-Educational:

ONLY those patients having an educational episode (attending a class in the System) will count in ADA 8th Edition statistics. The system determines who went to class during the requested time period, determines if they are Comprehensive/Initial, or Follow-Up, and then answers the population questions.

Comprehensive and/or Initial Education: Participants received an assessment that included relevant medical history, diabetes history, social history, diabetes knowledge, self-management skills and diabetes related behaviors in relation to the content areas of the National Standards, instruction in the areas assessed as needs, on-going assessment of knowledge and skill level and behavioral objectives. One outcome measure was tracked pre and post instruction. In the Diabetes Management System there are three ways the system determines who meets the Comprehensive/Initial criteria: Any participant who has attended an educational opportunity within the data period AND…

- Demographic File: The box, "Completed Other DSME Program" is **NOT** checked.
- Demographic File: Under General Tab, "Date Finished Program" field is blank.

Follow-Up (Post Program) Education: Participant has completed DSME previously and was seen for follow-up education, or limited consult. In the Diabetes Management System there are three ways the system determines who is considered Follow-Up Education:

1. Any participant who has attended an educational opportunity during the 6 months period of time and…
2. Demographic record has the box; "Completed Other DSME" program CHECKED.
3. Or the Date Finished Program in Demographics indicates the person finished this program at a time period ***prior to*** the beginning of your data period.

Curriculum

Class Curriculum Maintenance

All Educational Episodes are considered as "classes" in the System. The Class File contains all the education information that is used in the Participant Education Records. To set up this File, click on

EDUCATION/CLASSES > CURRICULUM > CLASS CURRICULUM MAINTENANCE.

All Look-Up Windows will be displayed to show the active Educational Opportunities (labeled classes here) loaded into the system. From this window one can add, update, or delete Classes. All opportunities are stored here (ie, 1:1's, classes, support groups, Initial Assessments, Insulin Starts, Pump Therapy, etc). Attendance Listing for a highlighted class allows for the printing of mailing labels or use of Mail Merge. To set up the system click Add. Each Detail Class Record contains the following information...

- Class Title (ie, Session 1, Class A, etc.)
- Length (in minutes)
- Required Class Status (is this class required for a comprehensive program?)
- Primary Teaching Method (ie, Lecture, Demonstration, Video, etc.)
- Class Format (ie, Class, Individual Session)
- CPT and HCPCS Codes, and Charge (used for Billing).
- Instructor Name (Optional – this is the instructor who designed/setup the course)
- Materials Used or Needed (Optional)
- Additional Comments or Notes (Optional)
- Inactive Class Check Box (Check if this class is no longer being offered)

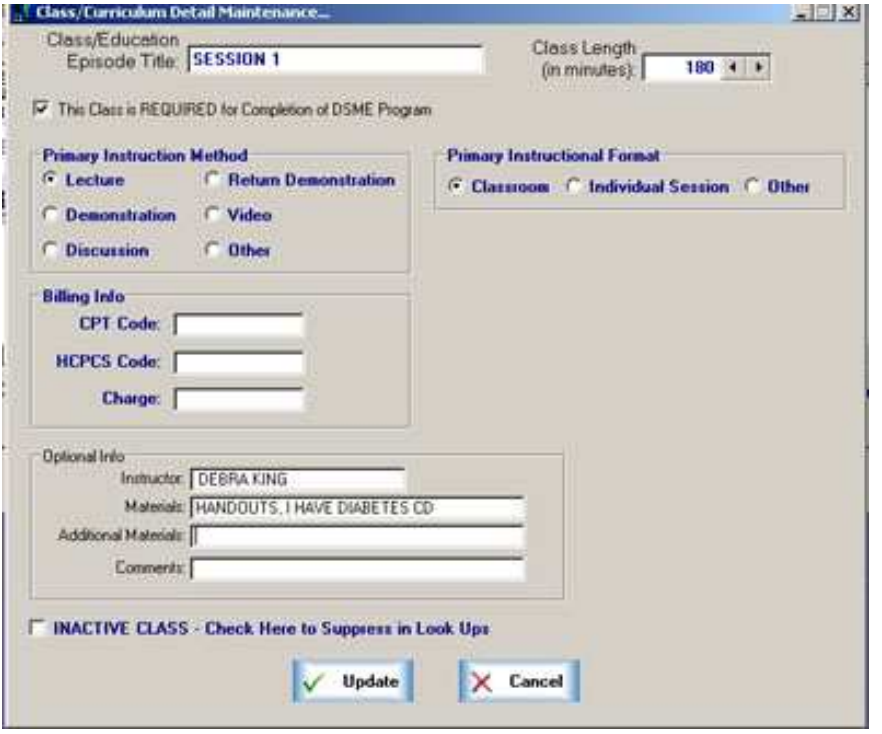


Fig. 7: A Class Detail Window

Class Charges/Financial Information

Version 5.3 added the capability to track departmental revenue, based upon charges for class/education time. The CPT and HCPCS codes as well as the charge for the class were added into the Class Record. If you do not wish to track charges, you do not need to enter this information.

NOTE* If you add or change class charges, the information is not retroactive. It will only affect class attendance from the time the charge was added or changed, forward.

Required Class Information

Many Education Departments have requested a method to determine who has or has not completed a "Comprehensive" program, rather than just checking the box in Demographics. This feature works best if you have only one set of required classes. For example, you work mainly with group classes and your institution believes that a "Comprehensive" program is:

- Initial Assessment
- Class A
- Class B
- 3 Month Follow-Up

To indicate which classes are required, go to Class/Curriculum Look Up. You can double click on a class to toggle the Required column on and off. You can also modify the required status in this class' detailed record.

Content Areas/Class Link Maintenance

This file contains the Content Areas for the National Standards. They can be altered, deleted, combined, or added to by you as the Standards change. It is best to use "Is Able To" statements that cover the Content Areas and describes what is taught in the corresponding class. Each content area statement will need to be **linked** to the appropriate class or classes.

Verify that every Content Area has at least one class linked to it AND that every class is linked to all its appropriate Content Areas.

To relate a content area statement to the appropriate class, highlight a Content Area from the list, click Update and use the ellipsis buttons to access Class Lookup. Highlight the class and click on Select. Each Content Area can have up to eight different classes linked to it. Review that all classes are appropriately chosen and click on Update. To review your class list and appropriate statements, click on Education/Classes > Educational Reporting > Assessment Area Listing. After all your classes are linked to the appropriate assessment area statements, putting a client in a class will also fill in the date taught section of the client's Educational Assessment for that Content Area.

How to Change Content Areas

To replace, add to, or modify Content Areas, click...

Education/Classes > Curriculum > Content Areas/Class Link Maintenance.

To change both content area and statement highlight group name and description and click on delete. Click on Add. Type in the statement that best describes what the client learns(Content Description #1 and #2) on the Content Area (Group Description). Use the ellipsis buttons to select all related classes (up to 12), in which the content area is covered. To change existing content areas, highlight statement, click on Update, alter statement and click on Update.

Scheduling by Class

To schedule participants by class go to Education/Classes > Scheduling by Class. At the class look up window highlight the desired class and enter the date of the class below. Click on *Schedule>>* button to schedule patients for this class. Double click on the patients to be scheduled. A Successful Add pops up indicating that this class was successfully scheduled for this patient. Click OK.

Please Note: This does not enter that patient as having attended the class. To get a class schedule and mark patients as having attended, go to **EDUCATION/CLASSES > ATTENDANCE > SCHEDULED ATTENDANCE.**

Recording Class Attendance

Individual Education Record

Click on **Patient > Pathway > Individual Education Record,** or **Education/Classes > Attendance > Individual Education Record.**

Click Add, and use the ellipsis Buttons to fill in class code, class date, and instructor. Then review your data and click on Update to save your information.

Group Class Attendance/Unscheduled

To put a list of participants into a class click on **Education/Classes > Attendance > Group Class Attendance/Unscheduled.** A window will display a listing of educational opportunities. Highlight the class, then use the ellipsis buttons to fill in class date, location, and instructor and the # of times this class was taught on this day. Once these fields are filled in, click on Next. A list of participants will be displayed. Double click on each participant that attended a class. A message box will be displayed that states This Class Record was Successfully Added for this Patient.

Scheduled Attendance

To record attendance at scheduled classes go to **Education/Classes > Attendance > Scheduled Attendance**. Highlight the Class Title. A list of dates will appear on the right for past and present scheduled classes. Double click on a date and a class list will follow. Mark those that attended by highlighting their name and click on Mark as Attended, select the Educator, and select the Class Locator. Or if everyone on the list attended, Mark ALL as Attended. Print will provide a Class Schedule Listing which includes whether a participant attended or not, home and work phone numbers are provided. By marking a participant as Attended, this class will appear in their Individual Education Record.

Educational Reporting

Individual Patient Class Schedules

This option can be accessed by clicking on **EDUCATION/CLASSES > EDUCATIONAL REPORTING > INDIVIDUAL PATIENT CLASS SCHEDULES.**

To find if a particular patient has been scheduled for a class, highlight their name and a list of scheduled classes appear to the right. This window only lists scheduled classes, not classes added to this participant's record from their Individual Education Record, or from Group Class Attendance/Unscheduled. For a thorough list of a participant's education history, go to **Education/Classes > Attendance > Individual Education Record**, then highlight the patient name, click on Education, then Print.

Participant Educational Assessment

The Educational Assessment is used to keep track of a participant's journey through a comprehensive program using the Content Areas as a guideline. When Class/Curriculum Information is linked to all appropriate Educational Assessment Areas the date taught field is completed automatically. To Access a Patient's Educational Assessment, click on the "Educational Assessment" button from their Pathway. This window displays all the Content Areas with any appropriate data for this patient record. The Educational Assessment Update can easily updated from this window.

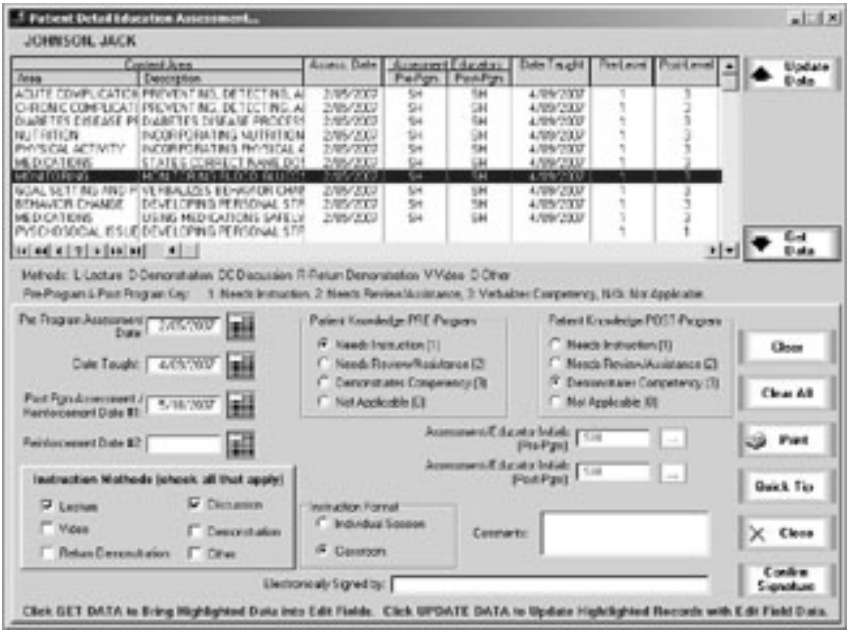


Fig. 8: Detail Education Assessment Window

You can manually update the detail records two ways....

Update all the appropriate information at the bottom of the window, click once on the Content Area above to highlight it, then click the Update Data button. Or you can highlight the appropriate Content Area once to highlight it, then click on the Get Date button to fill in all the

appropriate fields. You can edit any or all the fields, then click the Update Data button to update that Content Area with the new, edited data.

Updating Multiple Content Areas with the Same Data

You can update multiple Content Areas with the same data easily. Highlight the Content Area with the data you wish to use and click GET DATA. This will bring the data down into the lower part of the window to be used/modified. To update the other Areas, highlight the desired Area, then click the UPDATE DATA button.

Clearing Educational Assessment Record Data

The Clear button will clear out all the data for the highlighted Content Area. The Clear All button will clear out ALL data for ALL Content Areas for this Patient.

Class Activity Listing

For a synopsis of all classes taught in a requested time period run a Class Activity Listing **(EDUCATION/CLASSES > EDUCATIONAL REPORTING > CLASS ACTIVITY LISTING).** This report lists the name of the class, Total Time Taught, and the Number of Attendees.

Required Class Attendance Report

To indicate which participants have or have not completed a comprehensive program, go to **EDUCATION/CLASSES > EDUCATIONAL REPORTING > REQUIRED CLASS ATTENDANCE.** Fill in the appropriate patient program dates and whether you want a Completed or Not Completed Report. Filter by start dates, end dates or agency code (all found in the Demographic File under the General Tab).

To set up which classes are required, refer to "Required Class Information" in the Curriculum section above.

Assessment Areas Listing

This report displays all the Content Areas, along with all the related classes (that are linked to it). Previewing this report gives you a quick look at all content areas, related statements and all related classes. **(EDUCATION/CLASSES > EDUCATIONAL REPORTING > ASSESSMENT AREAS LISTING)**

Curriculum Listing

This report lists all your classes, along with any instructor information (from the class detail) along with the appropriate Content Area(s) it is linked to. **(EDUCATION/CLASSES > EDUCATIONAL REPORTING > CURRICULUM LISTING)**

Clinical/Assessment Flow Sheet

Adding Participant Assessment Data

Patient Assessments is used primarily to record clinical and behavioral outcome information.

Participant Assessment Data Records are based on visit date. Participants can have multiple Assessment Records. Assessment Records contain specific participant visit and lab value data. Most Outcomes Reports use the data from Assessment. Highlighting the appropriate participant in the Look Up Window, and click on **Pathway > Assessment.** Click Add to add a new assessment or Update to update an existing Assessment. Enter the date of the assessment and the Follow Up Status Code (why the participant is being seen). When you access a Participant's Assessment Record, you will see the data organized with various TABS along the top of the window. You can bring the appropriate information to the top of the window by clicking on the corresponding tab.

Using Prime New Assessment With Prior Data

By using Prime New Assessment With Prior Data you can prime information from prior assessments into this new current assessment. Note – this option was inserted at the requests of several sites that require this. ***Do not use this if you are not required to. Contact Harbor Software for more information or before using this option.***

Medical Nutritional Therapy

DSMT and MNT are distinct but complimentary services. Both are necessary for quality diabetes care.

You will need to design your program so that all eligible Medicare beneficiaries have appropriate access to both benefits and to accurately document what is being provided and what program is being reimbursed. MNT hours are often kept separate from the DSMT hours. The DMS allows you to decide what should and should not be counted in DSMT. RD's may use Assessment to accurately track Medical Nutritional Therapy. Highlight the Participant, click **Pathway > Assessment > Add.**

Enter the appropriate date; use the Follow Up Status Code of MNT. Indicate the number of minutes that you spent with the participant by filling out the Length in Visit (in minutes) box, Click Update. To get a report go to **Reports > Activity Listing > Activity Reports**, fill in date period, click on down arrow in the Follow Up Status Type box, choose MNT, then click on Detail Report. If the RD's teaching should be counted in DSMT, the nutrition classes must be in Class/Curriculum Information and participants put in class by the individual or group class record.

Goals Module

Behavioral Goal

Maintain Behavioral Goal Groups under **FILE > SYSTEM FILE MAINTENANCE > BEHAVIORAL GOALS.**

Participant Behavioral Goal

The DMS System allows for unlimited customization of individualized recording, tracking, and reporting of Participant Goals. For Participant Goals and DSME Goals (that you set for the participant), click on **Patient | Pathway | Goals.** All previously set goals for this Participant along with their status is now displayed in the window. From here, you may add new goals, update the status of existing goals, and/or add new ones by clicking on the appropriate buttons at the bottom of the window. Each Goal Record has the following information...

- The Date the Goal was set.
- A Description of the Goal (up to two lines).
- Goal Date (When does participant want to meet this goal).
- The Date the Goal was Met.
- Behavioral Group (these are maintained in System File Maintenance – see above).
- The Degree of Achievement of the Target Goal (in percent).
- How Often did you meet your Goal (in percent, for each follow-up visit).
- How will this behavior positively affect your health or quality of life? (free form statement).
- What did you learn from working on this goal? (free form statement).
- Date areas for 1st, 2nd, 3rd, and 4th Follow Up Visit.

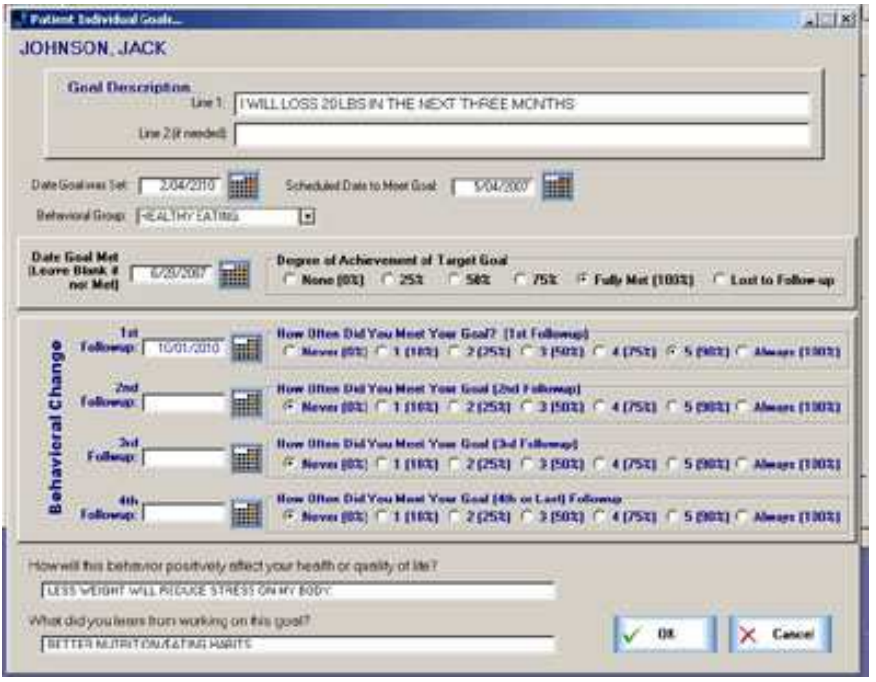


Fig. 8: Detail Patient Goals Window

Default Goals

You can set up templates of your standard Default Goals in order to save redundant typing. Default Goals are created and maintained under **File > System File Maintenance > Default Notes and Goals > Default Goals.** Click Add to add a goal. Goal Line 1 and 2 are for the statement, ie, "I will test my blood sugar 3 times a day". Associated Behavior Group categorizes the goal so it can be measured in outcomes reports. Standard responses can be filled in for the Quality of Life statements and can be added to or modified in the Participants Goal record. From the Participant's Pathway click on **Goals > Add** and fill in the date the goal was set and click on Default. Highlight and Select the Goal Statement. Modify or add to the goal then click on OK to save this goal. Please note, each Add is for **ONE** goal statement. Participants can have many goals listed on their Goals Look Up window.

Goal Reports

- Participant's Goal Record, go to the Patient List, highlight their name > Pathway > Goals > Print Goal Status Report. This report lists all goals for this participant, behavior group, and current goal status met. For an evaluation of a participants progress towards/or achievement of learning and behavioral objectives and related outcomes, highlight their name > Goals > Print ADA Goal Assessment.
- Blank Goal Setting Form, from any participants Goal Look up, click on the Print Blank Goal Setting Form, or Reports > Blank Forms > Blank Patient Goal Setting Form.
- Goal Follow-Up Date Status. A report for tracking follow up dates, including percentages of Goals Met, and percentages of participants that had 1st, 2nd, 3rd, or 4th follow up dates.

Medication Module

The Medication History file is used to store an unlimited drug history. The Medication History is accessible through the patient's pathway or Assessment. To add medications, click on Pathway | Medication History | Add. The following information can be stored:

- Name of Drug (use the ellipsis button to the right to access Medication File)
- Start date
- Dosage
- Frequency
- Comments
- Ordered by (use the ellipsis button to access Physician File)
- D/C date

To print a medication history, highlight the participant and click **Pathway > Medication History > Print.**

Complications / Issues Module

The complication file is used to store various complications or issues experienced by your participants for tracking purposes.

Adding Complications

To add complications or issues click on **COMPLICATIONS > COMPLICATIONS.** Click Add and put the complication or issue in the description text box. Click Update to save your work.

Tracking Participant Complications

The System can track an unlimited number of complications per participant. For each complication, the following information is stored:

- The Type of Complication. Click on the ellipsis button to look up the various complications stored on your system.
- The Date this Complication was identified. Clicking on the ellipsis button will display a calendar to assist with date selection.
- The Date this Complication was resolved (if applicable).

A listing of all the complications for a participant can be obtained by clicking on the PRINT button. These complications will also print on the participant's assessment sheet and recognition assessment form. Click on **FILE > PARTICIPANTS > ASSESSMENTS**, highlight a date and choose print option.

Complications Summary Report

To print a listing of all participants in your system with a certain issue or complication go to Complications | Highlight the Issue or Complication | Report. The Report gives you a list of names, record numbers, date identified and date resolved and can be filtered by date. For a filtered Complication Summary go to **REPORTS > PATIENT LISTINGS > FILTERED COMPLICATION LISTING.**

Filtered Complications Listing

To print a listing of all participants in your system with a certain issue or complication go to **Reports > Patient Listings > Filtered Complication Listing.** Click the appropriate Filters and Dates, and then fill in the complication by clicking on the down arrow in the Complication Box. The Report gives you a list of names, record numbers, date identified and date resolved.

Podiatry Module

Overview...

The Podiatry Module is designed for recording and printing detailed foot assessments.

To begin, go into a patient's Pathway, then click PODIATRY. Highlight the appropriate participant and click on the Podiatry Button. A participant may have multiple Assessments based on Date. A small pop up window will display the different assessment dates. To add a new Assessment, click on the Add button. To modify an existing Assessment, highlight that Assessment date and click on the Update button. The only required field is the Assessment Date on the General Information Tab. The Detail Podiatry Assessment has the following sections...

- General Information
- Nail / Ulcer
- Callous / Corn
- Vascular / Pulses
- Vascular / Skin
- Neuro 1 (Vibration Test, 5.07mm Filament Test) - this section is displayed below.
- Neuro 2 (Reflex, Pain perception, Strength)
- Biomechanical

Printing the Podiatry Report...

The Podiatry Report is a detailed, four page report for a participant. On the patient's Pathway, click on the Podiatry button. Highlight the desired Assessment Date and click on the Print button.

Graphing

A Graphing Module is in the Pathway. Graphs can be generated for the following Assessment outcome data point values... Weight, HbA1c, Cholesterol, LDL, HDL, Abdominal Girth, ALT, AST, GFR, TSH, Systolic B/P, Diastolic B/P, Following Meal Plans, and Regularity of Self Foot Exams.

The Outcome data points are on the vertical axis and the Visit History are on the horizontal axis. Right mouse click on the graph to open a window for several display options, including a print option.

Nutrition Module

The Nutrition Module has three functions...

1. Automate a Nutrition History / Meal Plan. This breaks servings down to CHO, Protein, and Fat Calories as well as calorie percentages.
2. Diet History / Diet Factors. This records, stores, and prints out 14 Nutrition Factors and how they affect this participant's nutrition.
3. Diet Plan Worksheet / Meal Chart. You can print out a blank form for the participant to complete at their convenience for later entry into the system.

Nutrition History / Meal Plan...

To begin, click on **FILE > MEAL PLANNING.** Highlight the Participant you wish to generate a plan for and click on the Meal Plan button. Participants may have multiple plans. The only required fields are the Meal Plan Number, and the Date.

This window automatically calculates calories and percentages of total diet based upon the number of servings entered when the Tally button is pressed. To override the tallied carbohydrates click the "Use Entered Carb Choices in Tally", enter your own numbers and click Tally.

FOOD GROUP	CHO Calorie Multiplier	Protein Calorie Multiplier	Fat Calorie Multiplier
Starch	15	3	1
Fruit	15		
Milk - Skim	12	8	1
Milk - Low Fat	12	8	5
Milk - Whole	12	8	8
Vegetables	5	2	
Meats - Very Lean		7	1
Meats – Lean		7	3
Meats-Med Fat		7	5
Meat - High Fat		7	8
Fats			5

The Update button will update the entered this data and returns to the Participant Lookup Window. A sample window is displayed below...

Meal Planning Worksheet...

A Meal Planning Report can be printed by highlighting any participant and clicking on the Meal Chart button.

Diet History / Diet Factors

Click on **FILE > NUTRITION** (or click on the Nutrition button in the Patient's Pathway). Highlight the Participant you wish to maintain nutrition factors for and click on the Diet Factors button. A sample Factor Window is displayed below. You may enter factors as appropriate. Click on the OK button to save the data you entered. Clicking on the Print button will generate a detail Nutrition Factors report for this participant. You can generate an aggregate report of all participants between two dates that have an entry for a particular factor. This report can be printed by clicking on the displayed Print button.

Charting/Letters Module

The System has the ability to generate and store narrative charting and SOAP Note charting by date, by participant. It also has the ability to generate automated, stock letters for participants, physicians, agencies, etc.

Narrative Charting

Narrative Charting is accessed in the Charting Option under the FILE menu. For convenience, it can also be accessed in several other sections of the system, in the Progress Notes, and in Participant Assessments. Click on Charting, then Narrative Notes. The Window displays an alphabetical list of the participants. Highlight the participant and click on Select. A Participant Narrative Note Window displays a narrative note history. You can add, update, and print out notes by pressing the appropriate button at the bottom of the window. Go to: **FILE > SYSTEM FILE MAINTENANCE > DEFAULT NOTES AND GOALS.** Here you can add, delete, or Update existing notes. To add a narrative note to Charting, Assessments, Progress Notes, just click on ADD, select a date; Select a Default Note from the Drop Down List. This note can be altered or added to. You must include a signature.

Default Narrative Notes

Default narrative notes to be stored and used at any time. **File > System File Maintenance > Default Notes and Goals.** Here you can add, delete, or Update existing notes. To add a narrative note to Charting, Assessments, Progress Notes, just click on ADD, select a date; Select a Default Note from the Drop Down List. This note can be altered or added to. You must include a signature.

SOAP Notes

SOAP Note Charting can be accessed in the Charting Option under the FILE menu. Click on Charting, then SOAP Notes. The Window displays an alphabetical list of the participants. Highlight the participant and click on Select. A Participant SOAP Note Window displays a SOAP note history. You can add, update, and print out notes by pressing the appropriate button at the bottom of the window.

Default SOAP Notes

Default SOAP notes can be stored and used at any time. Go to **System File Maintenance > Default Notes and Goals > Default SOAP Notes.** Here you can add, delete, or Update existing notes. To add a SOAP note to Charting, or Pathway, just click on ADD, select a date, and Select a Default Note from the Drop Down List. This note can be altered or added to. You must include a signature.

Progress Notes

A simple Progress Note can be quickly generated for the referring physician or for your records. To generate a Progress Note, click on Patients, Highlight Patient, Pathway, and then Progress Note. A calendar will be displayed to choose the date of this note. Click on the desired date and then on the OK button to continue. Another window is now displayed showing all the Procedures loaded in your Procedures File. Select all the options or procedures that apply, then…

To add an existing Narrative Note to this report: Click Print and select an existing narrative note, Click Next…review the printed progress note.

To create a Narrative Note to add to this report: Once you have selected the options or procedures, Click Narrative, ADD, select Date, Create a new note or use the Default Note Button, select a stock narrative note. Sign, Update, and then Close. Click Print and select this note, Click on Next… and review the printed progress note.

Scheduled Activity

To add a (non-class) Scheduled Activity for a participant, highlight a name and click on Pathway, then Scheduled Activity. A Scheduled Activity can be maintained for each individual and printed for his or her convenience. To print an aggregate list of everyone that have scheduled activities between two dates, click on **REPORTS > ACTIVITY LISTINGS > SCHEDULED ACTIVITY LISTING.**

Letter Generation

The System can store an unlimited number of standard letters (up to approximately one page). Once they are entered and stored, you can simply select a physician, participant, or agency and generate a letter. This is very useful for generating standard follow up letters, referral letters, education notes, etc. Click on FILE, LETTERS, and then STOCK Letters. You can add, update, or delete your stock letters here. Some letters are supplied for you to use or alter. Update these letters to see how they are designed. Click Add to add a new letter, Update to save those changes. Use the Description to name your letter so it is easily identified, ie Referral Letter, Class Promotion Letter. This Description does not print.

You can generate a stock letter by clicking on **FILE > LETTERS > PATIENT LETTERS.** Highlight the participant you wish to generate a letter for, then click on the GENERATE button. A window will appear displaying all the stock letters in the system. Highlight the letter you wish to use, enter the name of the signer, and click on LETTER for a generated letter or CHART for a generated chart entry.

Letters to Physicians, Specialists, or other Agencies can be generated in the same way by clicking on **FILE > LETTERS > PHYSICIAN/OTHER LETTERS.** All generated letters are designed to print on your institution's letterhead. There is approximately 2.5 inches of space at the top of the letter to accommodate your letterhead. To set your own margins and font go to **System File Maintenance > System Default.**

Letter Generation Margins and Font Sizes

Top and Left margins and font size are adjustable. Go to **FILE > SYSTEM FILE MAINTENANCE > SYSTEM DEFAULTS.**

Mail Merge

Mail Merge Data File Generation was added to the system for Participants and Physicians. This module will generate an ASCII data file that can be used as a data source in almost any word processor that has mail merge capability.

Step-by-Step Instructions…

1. Start the Diabetes Management System.
2. Click on Reports.
3. Click on Labels/Mail Merge
4. Click on Mail Merge…
5. Finally, click on Participant Mail Merge.
6. The Participant Mail Merge Dialog Window will now be displayed. This window allows you to select:
    g. The fields to export
    h. Selected Participants by: Gender, Diagnosis, Referring Physician, and Insurance
    i. Field separator (default is a comma) in the export file.
    j. The Output Path/File Name.
11. Click on the browse/lookup button to the right of the File Name in order to select the appropriate path and file quickly.
12. Click on OK to begin the export and generation of the merge data file. You will see a message line on the lower left of the window listing names export.

A message will be displayed notifying you that the export is completed.

13. At this point, you can exit from the Diabetes Management System and start the program that uses mail merge. This generated file will be used as the data source that will place the data fields you select into your document.
14. Please note that if you regenerate this data into an existing file, the file will be overwritten and the prior data will be erased.

Mail Merge from Class Attendance

A Mail Merge Data File can also be generated from Class Attendance Information.

1. Start the Diabetes Management System.
2. Click on Education/Classes
3. Click on Class Information
4. Highlight the Class you are interested in and click on the Attendance button.
5. On the Attendance Dialog Window that is displayed, select the "from" and "to" dates, and click on the Merge button. Note that the from and to dates are exclusive of the selected dates. For example, if you wished to generate a listing for just one day (2/15/07), you would have to put "the from" date as 2/14/07 and the "to" date as 2/16/07.
6. The Participant Mail Merge Dialog Window will now be displayed. This window allows you to select: the fields to export, the field separator, and the Output Path/File name.
7. Continue on with Step #7 above.

Telephone Logs

Telephone Logs are used to record (log) telephone contacts to and from participants, multiple entries per day can be entered. It can be found in the **FILE > CHARTING/LETTERS >CHARTING > TELEPHONE LOGS**, or select a participant > Pathway > Telephone Log. A log can be printed from an individual file. For a detailed list of all Telephone Log entries for any time period, go to Reports > Activity Listing > Telephone Log Listing. Detailed information on the call can be recorded in a Narrative Note.

Glucose Logs

Track daily or multiple daily Blood Glucose Levels as well as Insulin Dosing. Click on **FILE > CHARTING/LETTERS > CHARTING > GLUCOSE LOGS,** or highlight a participant, click on Pathway, and Glucose Logs. You can ADD, UPDATE, EXPORT or PRINT from here.

Participant's Charts

A chart can be printed from the Participant's Pathway. Highlight Participants name, click on Pathway. Print Face Sheet and Assessment Sheet. These reports contain a history and assessment of this participant. A recognition initial assessment form can be printed from the assessment look up window.

ADA Recognition (8th Edition)…

The DMS System collects and can tabulate the data required for the ADA Recognition Worksheet for any data period length (the default length is 3 months for 8th Edition).

Reports > ADA 8th Edition Reporting > Application Worksheet.

ALWAYS CHECK FOR THE LATEST INSTRUCTIONS/DOCUMENTATION

AT THE ADA WEB SITE, http://professional.diabetes.org/

- Click on "**Recognition Programs**" Menu Option on the left side of this window.
- Click on the "**Education Recognition Program**" Link at the top of this window.
- Click on "**Applying for Recognition Link**" located on the right side of this window.
- Download the "**Application Instructions**" and the "**Application Form Template**" for review.

We suggest you contact Harbor Software at the beginning of your data period to set up an appointment where we can go over the Application and how to use the Diabetes Management System to periodically verify if you are on track during your data period, as well as identifying and correcting any errors or missing data.

The System can automatically generate the Application Worksheet, your Outcomes, Goals, Assessments, as well as many audit reports that can be used to back up your data, in case of a ADA audit.

How the Participants are tallied for Recognition

Only those participants recorded as having educational episodes within the Data Period are counted for Recognition. Therefore, ONLY those participants put into classes in the Education/Class Module (Individual Class Record, Group Class Attendance, or Pathway > Individual Education Records) will show up in these statistics.

The system first looks through this module determining who went to class during the requested time period, determines if they received Comprehensive/Initial, or Follow-Up Education, and then answers the population questions. In order to have accurate information for your recognition application you must maintain good class records. To get a good idea of what information you need to maintain in the system look at the Worksheet under **Reports > ADA 8th Edition Reporting > Application Worksheet.**

Site Information: Total number of participants who received DSME intervention at this site during the data period.

Comprehensive and/or Initial are those participants who are put into classes from Education/Classes > Group or Individual Classes *during* the time period you have chosen, **AND** the completed this (or other) DSME program box is NOT checked in demographics **AND** the Date Completed Program is **NOT** entered, **OR AFTER** your Data Period Start Date.

Post-Program (Follow-Up) participants are those participants who have received education from you also during this time period AND the completed this (or other) DSME program IS checked, or they completed your program PRIOR to your Data Period Start Date. The system will tally up class time as average number of hours for both types of participants.

Population Information: This information is pulled from the demographic file.

- Age
- Type of Diabetes
- Race
- Barriers to learning

Instructors at the site:

Keep staff information under File > Staff Profiles. Maintain licenses for RN, RD etc., and the system will fill out the recognition application with how many RNs, RDs, and others you have working as instructors. Make sure to keep your CEU records up to date, back up your system. The correct report is **File > Staff Profile > CEU's > Print > Detail and Summary.**

Curriculum at the site:

There is a written curriculum with measurable learning objectives in each of the following areas: First develop a class list from Education/Classes. A class must have the amount of time filled in (average). Choose the content area or areas that you cover in class. Be creative. If you teach the same class to someone with a barrier to learning and it takes longer, make a class entry that's indicating extra time, ie Session 1 Basics/Special. Be sure to add support groups, follow up sessions etc. Put participants into classes by group entry or individual class entry. The Education Assessment should contain "Is Able To" statements to describe what a participant is expected to know on a content area. Your classes (or one on ones) should be linked to these statements.

Supporting Documentation:

Print the required documents to back up your DSME data. (**Reports > ADA 8th Edition > Supporting Documents)** The reports available are:

- Participant Detail Audit (Details Comprehensive vs. Follow Up)
- Age Breakdown Detail (from Demographics > Date of Birth)
- Diagnosis Breakdown Detail (from Demographics > General | Diabetes Diagnosis)
- Race Breakdown Detail (from Demographics > Race)
- DSME Intervention Detail (from Education/Classes Module)
- Special Needs Detail (from Demographics > Management Issues 2 > Barriers to Learning)
- Pre and Post Knowledge Test Results Detail (from Demographics > General Tab)

Instructors at this site: **File > Staff Profiles > CEU's > Print > Detail and Summary**

DSME Education Hours per Instructor: **File > Staff Profiles > DSME Hrs > Print**

Curriculum at this site: **Education/Classes > Curriculum Listing and Assessment Areas Listing**

Educational Assessments: **Patients > Pathway > Educational Assessment > Print**

Behavioral and Clinical Outcome Tracking

Before starting your Data Period, you must choose what behavioral outcomes you are tracking and then keep that information up to date. The System can track over 70 different Outcomes. Most of this information is pulled from the Goals and Assessment Modules. Remember, for Clinical Outcomes, you must have two or more different clinical outcomes per participant to obtain a report.

Educators DSME Experience Record

This report was added to help a team member:

- Keep track of the average number of hours of DSME experience per month during the 12 months prior to the start of the data collection period.
- Keep track of the number of hours per month they were involved in DSME during the data period.
- Maintain records of DSME hours for credentialing.

Make sure all members of the team are listed in Staff Profile (under File). When a participant is put into class (from Pathway, Group Class Attendance, or Individual Class Record), use the ellipsis button next to Instructors Initials. Highlight the educator, click on Select and then Update to save. This attributes these hours to that educator. To get a report by educator, go to **File > Staff Profile,** highlight the educator and click on the DSME Hrs button. From here you can Print, Add, Update, Delete, and Close. Using Add from here allows for manually adding classes. This is useful if more than one educator teaches a class. Click Add, highlight the class taught, and fill in the date of class and the minutes

credited to you. This does not alter the original class information. Update allows you to increase or decrease minutes of time attributed to an educator. This is useful if an educator teaches a class more than once in one 24-hour period.

ADA Annual Reporting Response Worksheet.

REPORTS > ADA ANNNUAL REPORTING > ANNUAL REPORTING RESPONSE WORKSHEET

As of May, 2010, the ADA has created an Online Annual Status Report (Online ASR).

ALWAYS CHECK FOR THE LATEST INSTRUCTIONS/DOCUMENTATION

AT THE ADA WEB SITE, http://professional.diabetes.org/

Note: Education Recognition Program (ERP) requires all recognized programs to complete an Annual Status Report during the anniversary month of ADA Recognition. Failure to comply with this requirement may result into immediate loss of ADA Recognition.

The ADA Annual Reporting Response Worksheet generates the data necessary to prepare your Annual Reporting Response. It works in much the same way as the Recognition Worksheet. Simply set your annual data period and click on the Tally button. The total number of patients seen will be calculated.

The ADA also asks for the number of Medicare Patients seen. In the Worksheet, on Panel #5 "RECOGNITION STANDARDS 9->10", there is a filter to set the insurances you wish to count.

BE SURE TO SET THE MEDICARE INSURANCE (and any others you may want to view) BEFORE YOU RUN THE TALLY.

The Goals and the Standards must be entered by you.

Consultation Module

The Consultation Module allows the user to build an unlimited number of standard consultation notes that can be used for participants that are loaded into the Diabetes Management System. Each note can have an unlimited number of sections and standard responses. Once a particular consultation note is selected for a participant, the responses can be customized for that participant's situation.

The Consultation Module is made up of four sections.

Consult Types

The Consult Types allow you to set up and maintain the overview information for your consultation notes. The data maintained here is:

1. Consultation Type
2. Signatory
3. Signatory's Title

Consult Templates

This option is for maintaining the particular information (fields/sections and their associated standard responses) for each consultation note. You can Add/Maintain/ Delete individual consultation sections along with their standard response. After clicking on Manage Consult Types, the Consultation Line Item Lookup Window is displayed. Each individual section has the following information that can be maintained…

1. Consult Type. Enter the Consult Type Number or press the ellipsis button to open a Selection Lookup window.
2. Order # in Consult. This is the Section's Order Number (or line number) in this consultation note. Note that you may increment and decrement the number by using the up and down arrows that are displayed. This number increments in 10's. This is so that new sections may be easily added between existing sections in the future.
3. Consult Section. The name of this particular section (ie, Allergies, History, Education, etc.)
4. Standard Response. The normal response for this section (ie., Normal, Negative, etc.). These responses are pulled in when a participant consult is created and can easily be modified.

Create/Maintain Consult

This option creates new consultation notes for a participant as well as maintaining existing consultation notes. This process consists of several steps.

1. Select a Participant. A Participant Lookup Window will be displayed. Highlight the participant you wish to create a consultation note for and click on Select. You can quickly locate a participant by typing in the participant's first two letters of last name. The window will automatically scroll to the participant that matches your entry.
2. Select the date of consult. A calendar will now be displayed. Select the date for this consultation and click Accept.
3. Select the Consultation Type. Highlight type and click Select.
4. Modify the Consultation Note. The note, along with all the sections and standard responses are displayed. Any sections that need to be modified can be by highlighting that section and clicking Update. The notes can be printed from this window.
5. Printing a Consultation Note. Print will result in a consult note with your institutions name, participant's name, and date of visit, date of birth, gender, medical record #, and referring physician. A lab work section will print on the note if there is an existing Assessment Record on this date. The labs that print are: Ht, Wt, BMI, Abd Girth, HBA1c, Chol, HDL, LDL.

View Existing Consults

This option allows you to view all the consults created for a particular participant, as well as printing them. The consults cannot be modified from this option.

General Reports Module

The following is a list of Available Reports Located in the Reports Menu...

Preview - This toggles the System's Print Preview Feature on and off. A check on the line indicates it is turned on.

Report Locator

The Report Locator was added to quickly search, find, and navigate to any one of the 200+ System Reports. The Report Locator can be found in the Reports Menu. Search for the Report-by-Report Name or Report Group.

Participant Listings

Alphabetical Participant Listing – General alphabetical Participant List.

Filtered Participant Listing- Obtain lists of participants by any combination of filters.

Filtered Patient Telephone Listing – Listing of Selected Patient Telephone Numbers.

Filtered Complications Listing- Obtain lists of participants with certain complications.

Required Class Attendance Listing- Lists all patients who have (or have not) attended all the required elements of your program.

Participant "Referred By" Source Listing-How participants heard of your program (Demographics).

Onset of Diabetes List- Highlight New Onset Diabetes participants. (From Demographics| General Tab | Age at Diagnosis)

Completed Program Listing- Participant Listing of those who have completed DSME

Listing For A Selected Physician – Participant Listing by Physician.

Medications – Participant Listing of Selected Medication usage between two dates.

Insurance Listing – Participant Listing of Selected Insurances between two dates.

Pharmacies – Participant Listing of Selected Pharmacies between two dates.

Meter Types – Participant Listing of a Selected Meter Type.

Insulin Pump Types-Participant listing of a Selected Insulin Pump.

Case Manager – Participant Listing by Case Manager (from demographic file)

Dietitian Visit Listing- Participant Listing of participants who have seen a dietitian and when.

Nutritional Factors- Participant Listing by certain nutritional factors (from Meal Planning Module)

Number in Household with Diabetes- Participant Listing for multiple diabetic households.

Participant HBA1c/Lab Hx- Participant Listing of individual lab histories.

Participant Abdominal Girth History-Participant Listing with abdominal girth history.

Participant Height Growth Percentile History- Participant's height growth history.

Participant Weight Growth Percentile History- Participant's weight growth history.

Gestational Summary- Participant Listing with Gestational Diabetes

Expected Delivery Date Listing

Gestational GTT Summary

Baseline Acuity Listing

Missing Patient Data Listing- Lists all Patients with missing data.

Patient Contact Listing- Participant Lists with their Contact's Name and Phone Numbers.

Patient Log- Includes Names, Entry and Exit dates, and Referring Physician Name.

Analysis Reports

All the Analysis Reports are an aggregate collection of the participant data that meets any combination of the filters listed below. Clicking on ANALYSIS in the Menu Bar can access the Participant Analysis Reports. Each of these reports present aggregate system data between any two selected dates.

Gender - All, Males, or Females.

Race - All, Whites, Blacks, Hispanics, American Indian, Asian, or Other.

Age- All ages, or selected birth year range.

Marital Status - All, Single, Married, Divorced, Widowed, or Separated.

Occupation - All, Manual, Professional, Retired, Disabled, or Unemployed.

Diabetes Diagnosis Type.

Agency Code. This is an open-ended filter to use as you see needs arise.

HbA1c Range.

Zip Code.

Available Analysis Reports...

- Filtered Population-A Fifth Edition Recognition Report showing Percentages
- Demographics
- Initial Lab Values
- HBA1C
- Weight Analysis
- Hyperglycemic Episodes
- Hypoglycemic Episodes
- Management Issues- Report from Demographics | Management Issuers
- Favorite Ways To Learn -Report from Demographics | Management Issues
- Cultural Influences Listing- Information comes from Demographics | General

- Religious Influences Listing- Information comes from Demographics | General
- Income Levels- Report from Demographics | Contacts | Income Levels

Call Listings

This set of reports identifies participants in problem areas:

Eye Problem Call Listing - All participants with an identified Eye Problem

Dilated Eye Exam Status-All participants with last eye exam date.

Foot Problem Call Listing - All participants with an identified Foot Problem

Last Foot Exam Status- All participants with last foot exam date.

Hypertension Call Listing - All participants identified with Hypertension

BMI Problem Listing - All participants with a Body Mass Index greater than 26.

Cholesterol Problem Call Listing- All participants with a Cholesterol >200

LDL Problem Call Listing- All participants with a LDL >130

HDL Problem Call Listing- All participants with a HDL >60

Outcomes

All the Outcomes Reports are an aggregate collection of the participant data that meets any combination of the filters listed below. Clicking on OUTCOMES in the Reports Menu can access the Outcomes Reports. Each of these reports present aggregate system data between any two selected dates. **Please note that there must be two or more different sets of data on a participant in order for the participant's data to display (and count) in the report.**

Only Patients Marked as Completed in Demographics, or with a Completion Date

Gender - All, Males, or Females

Race - All, Whites, Blacks, Hispanics, American Indian, Asian, or Other

Age or Selected Birth Year Range- All, or any age range

Marital Status - All, Single, Married, Divorced, Widowed, or Separated

Occupation - All, Manual, Professional, Retired, Disabled, or Unemployed

Diabetes Diagnosis

Insurance Types

Agency Code

Zip Code

Referring Physician

Available Outcomes Reports...

Lab Work Outcomes

Blood Glucose	Microalbumin
Cholesterol	HDL Outcomes
LDL Outcomes	Triglycerides Outcomes
Creatinine Outcomes	Liver Function-ALT Outcomes
Liver Function-AST Outcomes	Thyroid Stimulating Hormone
Glomerular Filtration Rates	

HbA1c

Estimated Average Glucose (eAG)

Height and Weight Outcomes

BMI	Body Weight (in lbs)
Body Weight (in kg)	Weight Growth Percentile
Height Growth Percentile	Abdominal Girth
Blood Pressure	Self Foot Exam
Hospital Admissions Outcome	Length of Hospital Stay
ER/Urgent Care	Missed Days at School or Work
Nurse Visit Outcomes	Seen by Doctor Outcomes
Goals	Behavior Goals

General Health Rating

Initial Readiness to Learn Indicators (from Demographics)

Readiness to Learn Indicators Outcomes (from Assessments)

Nutrition – Following a Meal Plan (Assessment)

Acuity Level	Cigarette Smoking

Self-Monitoring of Blood Glucose

Hospital Admissions for Diabetes

Birth Weight

Goal Follow-Up Date Status

Screening / HEDIS Measurement Reports

There are 22 Screening / HEDIS Measurement Reports. Each report can filter data in a combination of ways: by date, Gender, Race, Age, Marital Status, Occupation, Diabetes Diagnosis, Insurance Type, Agency Code, and Zip Code. Each Report prints detail information along with summary totals and percentages. This information is entered in the participant's assessment file under the HEDIS/Screening Tab. These Reports are...

- Childhood Immunization Screen
- Adolescent Immunization Screen
- Breast Cancer Screen
- Cervical Cancer Screen
- Chlamydia Screen
- Prenatal Care in First Trimester Screen
- Check-Ups after Delivery Screen
- Advising Smoker to Quit Screen
- Management of Menopause Screen
- Blood Pressure Control Screen
- Beta Blocker Control after an MI Screen
- Cholesterol Management Screen
- Asthma Management Screen
- Comprehensive Diabetes Care Screen
- Follow-up after Mental Illness Hospitalization Screen
- Antidepressant Medication Management Screen
- Flu Shot Date Screen
- Yearly HbA1c Screen
- Dilated Eye Exam Screen
- Annual Foot Exam Screen
- Overall Health Rating
- Barriers to Learning

Referrals

Referral Analysis-Report on the percentage of participants coming from each physician.

Physician Referral Report- Lists Physicians and the number of participants referred to your institution.

County Referrals- Referral percentage by County.

Participant Referral Log- Lists Participants and the name of the Referring Physician.

Referrals to Outside Specialists- What Participants were referred out and why.

Referral Group Listing-Where referrals come from, i.e. Screenings, MNT, Community Health, etc.

ADA 8th Edition Recognition Reporting

Application Worksheet- Printout of on-line report filled in with appropriate detail.

Supporting Documentation:

1. Participant Detail Audit
2. Missing Data Audit

- Age breakdown detail
- Diagnosis breakdown detail
- Race breakdown detail
- DSME breakdown detail
- Special needs breakdown detail
- Pre and Post Knowledge Result Detail

NCQA Control Reports

NCQA Control Reports were added in version 5.7. This reports can be used for the NCQA Diabetes Physician Recognition Program. The available Control reports are:

- HbA1c
- Blood Pressure
- Eye Examination
- Smoke Status and Cessation
- LDL
- Nephropathy Assessment
- Foot Examination

NCQA Reporting Criteria

These Control Reports can be generated using two options, custom criteria and the NCAQ Standard Criteria:

Clinical Measures	Criteria
HbA1c Poor Control >9.0%*	≤15% of patients in sample
HbA1c Control <8.0%	60% of patients in sample
HbA1c Control <7.0%	40% of patients in sample
Blood Pressure Control ≥ 140/90 mm Hg	≤35% of patients in sample
Blood Pressure Control <130/80 mm Hg	25% of patients in sample
Eye Examination	60% of patients in sample
Smoking Status and Cessation Advice or Treatment	80% of patients in sample
LDL Control ≥130 mg/dl	≤37% of patients in sample
LDL Control <100 mg/dl	36% of patients in sample
Nephropathy Assessment	80% of patients in sample
Foot Examination	80% of patients in sample

Each Control Report generates the detail patient information as well as summary totals for each criteria, along with percentages.

Activity Listings

Activity Lists from Assessment Visit Records.

Activity Report- Lists all participant assessment activity between any two dates. Each line shows the type of visit, participant name, Medical Record Number, Sex, Birth Date, and Type of Diabetes, along with summary totals. This report can be filtered by type of follow up (mandatory field in Assessment), Case Manager (Contact field in Demographics), and Agency Code (optional field in Demographics). From this area reports can also be obtained for any Lab Activity, ER Visits with the option of printing Mailing Labels and Mail Merge.

Pre-Admit Report – Lists Selected Patients for Admissions, Registration, etc.

Tickler/Follow-up Report – This report prints all participants who HAVE NOT been seen for an assessment visit between a number of days (ie, between 0 and 60 days). Each line displays the Participant Name, Last Visit Date and Type, Medical Record Number, Sex, Birth Date, and Type of Diabetes, along with their home telephone number.

Scheduled Activity Listing- Shows all participants with any activity scheduled between any two dates along with the activity description and date. Information comes from Patient | Pathway | Scheduled Activities.

Participant Chronological Listing – Click Detail to Print summary assessment information for a selected participant in chronological order. Click Visits for a Patient Assessment Visit Log that includes the amount of minutes spent per visit and average number of minutes spent with patient.

Telephone Log Listing- Prints a summary of all telephone logs, alphabetically, then by date.

Mailing Labels and Mail Merge can be done from any of these listings.

Blank Forms

Blank Participant Demographic Form. Prints a blank demographic form. This is designed to assist with data collection away from the computer. The data on the form is in the same order as the Demographic Windows.

Blank Participant Assessment Form. Prints a blank Assessment form. This is designed to assist with data collection away from the computer. The data on the form is in the same order as the Assessment Windows.

Blank Patient Goal Setting Form. Prints a blank Goal Form with Signature lines and Quality of Life Statements.

Blank Knowledge Test- Prints out a blank knowledge test. To customize the test click on FILE | SYSTEM FILE MAINTENANCE | KNOWLEDGE TEST.

Blank Quality of Life- Prints out a blank Quality of Life Survey. To review or customize the Quality of Life Survey, go to | Quality of Life | Quality of Life Grouping or Quality of Life Questions.

Labels/Mail Merge

Mailing Labels ... Participant & Physician Mailing Labels. Prints 3-across mailing labels on standard Avery 5160 labels. Labels will not print out if participant's address is missing or they are marked deceased in the demographic file. Labels will not print out for Physicians if they are marked Inactive in the Physician Maintenance File. On Selective Mailing Labels, mark only those labels that you want to print.

Quality of Life Module

Overview...

The Participant Quality of Life Module has the capacity to measure participant attitudes in a variety of subject areas. The Module has the following features:

- Unlimited number of question groupings (ie, Physical, Mental, Participant Satisfaction).
- Unlimited number of questions within each group.
- Up to six different answer choices within each group (ie, Yes/No, True/False, Agree Strongly to Disagree Strongly, etc).
- The test can be printed or taken on-line.

Quality of Life Question Groups

These groupings identify the question subject areas as well as the answer range. To begin, do the following:

- Click on QUALITY OF LIFE | then Quality of Life Groupings.
- A look up list will be displayed showing the groupings that are already loaded (the system has some sample groupings loaded initially). This listing can be sorted by ID# or by Description. Click on the Add button to add a new group or the Update button to view the detail information of an existing group.
- You can add or modify the Description of this Group as well as the Results (up to six). Every question assigned to this grouping will have the choices that are displayed in this window.
- Click on the OK button to update this record or Cancel to exit without updating this information.
- To maintain your own test, delete all groupings then go to Quality of Life Questions and delete all questions. Go back to Q of L Groupings and click ADD. Group description is the name of your test or the name of this group of questions. You do not put questions in here. Next design the answers. You do not have to use all 6 results.

Quality of Life Questions

You can add, delete, and maintain all Quality of Life Questions. To begin, do the following:

- Click on Quality of Life, then Quality of Life Questions.
- A look up list will be displayed showing the questions that are already loaded (the system has some sample groupings loaded initially), along with their associated groupings. This listing is sorted by Question Number. Click on the Add button to add a new question or the Update button to view the highlighted question.
- There are three areas you can maintain per question; the Assigned Group, the Question Number, and the actual question text.
- Click on the OK button to update this record or Cancel to exit without updating this information.

On-Line Test

The Quality of Life Test can be given two ways:

1. It can be taken manually via a printed test. The results must be entered into the system manually at a later time.

2. It can be taken On-Line as you interview the participant. Click on Q of L > On Line Test > highlight participant > Use the Drop Down Menu to select a specific test > Select the Test date > click on Select.

Printing the Test...

Quality of Life > Print Quality of Life Test

Quality of Life Test Results

You can view a particular participant's test results very quickly. To begin, do the following:

- Click on Quality of Life.
- A look up list will be displayed showing all the participants loaded into the system. You can sort this listing by Last Name, by

Medical Record Number, or by Social Security Number just by clicking on the appropriate tab at the top of the look up listing.

- Highlight the participant whose test results you wish to view and click on the RESULTS button.
- You will be prompted to Preview this Report. Click on Yes to view the results on-line.
- The Participant Test will be displayed by group. Each question will have an "X" in the column with the answer the participant had chosen along with a date the test was taken. If the participant has taken this test multiple times, you will see multiple answers for each question along with the appropriate test dates. This way, you can see the changes in their answers.

Generating Quality of Life Statistics

The System has a report to list aggregate results of Quality of Life Surveys between any two dates. To do this, do the following:

- Click on Quality of Life.
- Click on Quality of Life Statistics.
- You will be prompted for the FROM and TO dates that will be included in this report. Enter the dates (in MM/DD/YYYY) format or click on the ellipsis button to the right of the date fields to display a calendar. This should be a period of time where you have entered in many participants answers pre-program (or at the beginning of your DSME).
- Select the Grouping to Print.
- You will be prompted to Preview this Report. Click on Yes to view the results.
- The Participant Test will be displayed by group. Each question will be displayed showing all the possible answers along with the number of responses participants made for each answer. The total number of responses will also be displayed along with the average of the responses.
- You can print a hard copy of this report from here or exit to the Menu.
- Post-Program, enter in answers and then run statistics for that new time period. Compare the averages of responses for pre-program to post-program.

Appointment Scheduler Module

The Staff Appointment Scheduler was developed at the request of several sites that wanted the ability to have a simple, centralized Appointment Scheduling System for their Staff. The Appointment Scheduler allows your staff to coordinate, view, and print their schedules across a network quickly and easily. The Appointment Scheduler allows you to set your own start and end times for appointments, set standard length of appointments for staff or classrooms, inactivate staff, and print daily or weekly calendars.

Scheduler Functions...

Setting up the Appointment Scheduler...

1. Load your staff into the Diabetes Management System. Start the Diabetes Management System and click on FILE | Staff Profiles. You will need to have the staff names entered, at a minimum. You can add additional staff and rooms within the Appointment Scheduler.
2. Start the Appointment Scheduler. It can be found by clicking on the "**Staff Sched"** toolbar button.
3. Click to highlight the desired Staff Member (or Classroom) and click SELECT.
4. The Appointment Schedule is very easy to use. All functions can be viewed and accessed from this one window. The main calendar in the lower left, and the associated daily schedule in the middle, and the function buttons along the right side of the window.

Update/Add an Appointment Time.

Highlight the appropriate start time with a single mouse click and click on the "Update" button (or simply just double click on the start time). The detailed appointment window will be displayed. The End Time can be modified with the left and right arrows, which will increment the end time in 15-minute increments. You have one line for an appointment description. The ellipsis button ("...") to the right of the description line can be used to display a list of participants. Selecting a participant will enter their name into the description line automatically. Click on

"Update" to enter this appointment and return to the Daily Detail Schedule.

Reserve a Time Block.

To Reserve a Time, simply highlight the appropriate start time and click on the "Reserve Time" button. This will block out this time with a "*** RESERVED ***" description.

Clear a Time Block.

To Clear out a time slot, simply highlight the time and click on the "Clear" button.

Block an Entire Day.

To Block out an Entire Day, Click on the "Day Block" Button. To Remove the Day Block, simply click on the "Day Block" Button again.

Print the Day's Schedule.

Click the "Print" button to print out the displayed schedule.

View and Print a "Week at a Glance".

Click the "By Week" button to view a 5-day "Week at a Glance" Schedule. This schedule can be modified and printed from this Week View.

Maintaining Staff and Rooms.

Staff and Rooms that need to be scheduled can be maintained by clicking on the "Staff/Rooms".

Maintaining Daily Start Times.

Click on the "Default" button to set up the default daily Start Time.

Delete Old Schedules.

Click on the Purge Button to delete all schedules prior to a specific date.

Quick Reference/Frequently Asked Questions…

What is the first thing I do in the System?

It is very important to set up the system before adding participants. Please feel free to contact Harbor Software for orientation to the System. Several System Files need to be updated and/or populated with pertinent records....

1. Enter your Staff under FILE | STAFF PROFILES
2. Enter your Physicians under FILE | PHYSICIAN INFORMATION (Note – you do not have to add all your physicians into the System prior to using it. You can add Physician Information as you enter patient data as well).
3. Follow -Up Status Codes. This is found under FILE | SYSTEM FILE MAINTENANCE | FOLLOW-UP STATUS CODES. This is used for participant assessment and is a mandatory field in Patient Assessments. Some institutions use initial visit, 3 month, 6 month, MNT, etc. You can update and delete the follow up codes you do not need.
4. System Default Information (FILE | SYSTEM FILE MAINTENENANCE | SYSTEM DEFAULTS) Use System Defaults to update your address/phone information, as well as default print margin info. Also, the most common Insurance Companies dealt with in the area. They will then show up on the demographic file. (For more information see Getting Familiar With The System, Setting Up the System.)
5. Set up your classes and link them to the appropriate content areas.

How can I quickly find a Participant in the System?

Click on the "Patients" button on the System tool bar, and all the Participants in the System will be displayed in alphabetical order. By clicking on the "by MedRec#..." and "by SocSec#..." tabs located at the top of the window, you can change the sort order to Medical Record or Social Security Numbers, respectively.

To quickly scroll to a specific participant name, simply type in the participant's last name. The System will scan automatically to the first name that matches with what you have typed.

How do I add a new Participant into the System?

Click Patients, and then click on the ADD button. If the participant already exists, click on UPDATE.

How do I add and update Participant Assessment Records?

Click on Patients. Highlight the Participant Record you wish to access and click on the ASSESSMENT button. A list of assessment records for this participant will be displayed. You can click on the ADD button to add a new assessment record or the UPDATE button to update the highlighted record. If you want to keep your data from assessment to assessment click on File | System File Maintenance | System Default and click on the Prime New Assessment with Prior Data. With each Add prior data will be loaded allowing you to compare new information with past information.

How do I enter our educational opportunities?

Click on EDUCATION/CLASSES then Curriculum. You can add or modify information here. Add all offered education opportunities that is provided (1:1, class, Insulin Starts, Support Group).

(See Getting Familiar with the System, Education Module)

How do I enter in a Participant's Education Record?

There are 3 ways to enter a participant into classes...

1. Pathway > Individual Education Record.
2. Education/Classes | Scheduling By Class, then go to Scheduled Attendance and mark as having Attended.
3. Group Class Attendance/Unscheduled

... go to the EDUCATIONAL MODULE Section of this manual for detailed information.

How do I enter in a Participant's Education Assessment Record?

Click on **EDUCATION/CLASSES > PATIENT EDUCATIONAL ASSESSMENT.** Or, click on the EDUCATIONAL ASSESSMENT button from the Patient's Pathway. Highlight the participant whose record you wish to modify and click on the SELECT button. The participant's record will be loaded with the Assessment Content Areas ready for you to update. Content Areas can be maintained through CONTENT AREAS / CLASS LINK MAINTENANCE by going into the ASSESSMENT AREAS option in this same pull-down menu. Using this feature you can supply written documentation of the participant's progress through the education program. Class dates will automatically fill in the Dates Taught if content areas have been linked to classes in the Education Assessment. (See Education Module)

How do I change my Behavioral Goal Groups?

Change Behavioral Goal Groups under **FILE > SYSTEM FILE MAINTENANCE > BEHAVIORAL GOALS. Do not Delete old Behavioral Goals. They are still needed for historical reporting.**

I don't use the computer when I interview a participant, what should I do to save time?

Print Blank Demographic and Assessment Forms from REPORTS > BLANK FORMS. These forms can be sent to the participant ahead of time or filled out partially while they wait. You may also want to print blank diet history forms from FILE | MEAL PLANNING | DIET FACTORS or MEAL CHARTS. All the blank forms match the screen to simplify data collection.

There are several of us who use the system, how can I get a list of just my participants?

In the participant's demographic file, Contact Tab, use the Case Manager ID. You can use a code, number, or short name. To get a list of participants click on REPORTS > PARTICIPANT LISTINGS | CASE MANAGER PARTICIPANT LISTING. Put in the date period you want and the Case Manager ID, Print.

The System has so much information, what do I concentrate on?

After you set up your system under file, the FOUR most important files/records to maintain are the Participant's...

1. Demographic Record,
2. Assessment Record,
3. Education Record.
4. Goals.

To be ADA recognized you need to decide what outcomes you are tracking. Once you have decided, be sure to keep that information filled out and up to date.

Where does the information for the ADA 8th Edition Worksheet and Supporting Documents come from in the Diabetes Management System?

ONLY those participants actually put into classes in the Education/Class Module are counted in these statistics. The system first looks through this module determining who went to class during this time period, determines if they are Comprehensive/Initial, or Post-Program Instruction (this used to be called "follow up"), and then pulls in the answers for population from Demographics. So in order to have accurate information for your recognition application you must keep good class records.

What information do I need to keep in the Diabetes Management System for Recognition?

To get a good idea of what information you need to maintain in the system look at the Worksheet under **Reports > ADA 8th Edition Reporting > Application Worksheet.** (See Recognition).

What reports do I need for the DSME 8th Edition Application and a Recognition Audit?

Supporting documentation **(Reports > ADA 8th Edition > Supporting Documents)** prints the required documents to back up your DSME data. The reports available are:

- Age Breakdown Detail (from Demographics | Date of Birth)
- Diagnosis Breakdown Detail (from Demographics | General | Diabetes Diagnosis)
- Race Breakdown Detail (from Demographics | Race)
- DSME Intervention Detail (from Education/Classes Module)
- Special Needs Detail (from Demographics | Management Issues 2 | Barriers to Learning)

Instructors at this site: File > Staff Profiles > CEU's > Print > Detail and Summary. File > Staff Profiles > DSME Hrs > Print.

Curriculum at this site: **Education/Classes > Curriculum Listing and Assessment Areas Listing.**

Education records at this site:

- An individualized initial assessment that includes relevant medical history, diabetes history, and social history: **File > highlight Participant > Assessment > Print Recognition Assessment Form.**
- A face to face assessment of the participant's diabetes knowledge, self-management skills and diabetes related behaviors based on the content areas of the National Standards: **Reports > Knowledge test**
- Results. Pre and Post Knowledge Test Results Detail. Quality of Life Statistics Report.
- An education plan, which includes measurable learning objectives, and participant, selected behavioral objectives based on the above assessments. **Goals > highlight Participant > Print Goal Status Report.**
- Educational interventions, which include the date of intervention, content taught and the names of the instructors. **Education / Classes > Educational Reporting > Patient Educational Assessment.**
- Evaluation of progress towards/or achievement of learning and behavioral objectives and related outcomes. **Goals > highlight Participant > Print ADA Goal Assessment.**
- Participant Outcomes: This depends on which outcome your DSME has chosen to track. Outcomes reports are under **Reports > Outcomes, or Reports > Screening/HEDIS.**

How does the Diabetes Management System determine who is Comprehensive/Initial or Post-Program Instruction?

Comprehensive and/or Initial education: participants received an assessment that included relevant medical history, diabetes history, social history, diabetes knowledge, self-management skills and diabetes related behaviors in relation to the content areas of the National Standards, instruction in the areas assessed as needs, on-going assessment of knowledge and skill level and behavioral objectives. One outcome measure was tracked pre and post instruction. In the Diabetes

Management System there are three ways the system determines who is **Comprehensive/Initial.**

1. Any participant who has attended a class during the 6 months period of time.
2. Demographic File: The box, Completed this (or other) DSME Program is **NOT** checked.
3. Demographic File: Under General Tab, Date Finished Program is blank or after the beginning data of your requested data period.

Post-Educational/Follow-Up: Participant has received initial or comprehensive education previously and was seen for follow-up education, or limited consult. In the Diabetes Management System there are three ways the system determines who is considered Follow-Up Education.

1. Any participant who has attended a class during the 6 months period of time
2. Demographic record has the box; Completed this (or other) DSME program, CHECKED.
3. Or the Date Finished Program in Demographics indicates the person finished this program at a time period prior to the time you have requested.

How do I keep track of my own hours of DSME experience?

Make sure all members of the team are listed in Staff Profile (under File). When a participant is put into class (from Pathway, Group Class Attendance, or Individual Class Record), use the ellipsis button next to Instructors Initials. Highlight the educator, click on Select and then Update to save. This attributes these hours to that educator. To get a report by educator, go to **File > Staff Profile**, highlight the educator and click on the DSME Hrs button. From here you can Print, Add, Update, Delete, and Close. Using Add from here allows for manually adding classes. This is useful if more than one educator teaches a class. Click Add, highlight the class, and fill in the date of class and the minutes credited to you. This does not alter the original class information. Use Update to increase the time spent teaching. This is useful if you have taught the class more than once in a 24-hour period.

How do I keep track of my hours of DSME experience if there are multiple instructors teaching one class?

The easiest solution is to break up the class into separate classes for each instructor. It is more accurate and will save a lot of time later on. Otherwise, when a class is taught by more than one instructor you will have to manually attribute time to each instructor from the Staff Module.

Participant Demographic Data File Export.

The Diabetes Management System Utilities can generate an export file containing Participant DEMOGRAPHIC data. The default name for this file is PTDEMO.CSV, but the user can change the path/file name just prior to creation of the file during the exportation process. This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel, etc) that is capable of importing ASCII files. The file layout is listed below. **(Note – You must have access rights to the Path and Folder this file is created in.)**

FIELD #	DESCRIPTION	LENGTH
1	Last Name	20
2	First Name	20
3	Middle Initial	1
4	Social Security Number	9
5	Birth Date - Month Number (1-12)	2
6	Birth Date - Day of Month Number (1-31)	2
7	Birth Date - Year (4 Digit)	4
8	Address - Line 1	30
9	Address - Line 2	30
10	City	20
11	State	2
12	Zip Code	10
13	County Code	3
14	Home Telephone	10
15	Work Telephone	10
16	Sex Code	1
17	Race Code	1
18	Multiracial Flag	1
19	Ancestry Code	1

20	Marital Status	1
21	Occupation Code	1
22	Insurance Code (NOT USED)	1
23	Insurance Types	6
24	Ambulatory Status	1
25	Agency Code	4
26	Medical Record Number	20
27	Spoken Language Code	1
28	Written Language Code	1
29	Years of Schooling	2
30	Highest Degree Attained	4
31	Age at Diagnosis	2
32	DM Type	1
33	Height	5
34	Weight	5
35	Consent Form Signed	1
36	Month Consent Form Signed (1-12)	2
37	Day Consent Form Signed (1-31)	2
38	Year Consent Form Signed (4 Digit)	4
39	Month Entered Program (1-2)	2
40	Day Entered Program (1-31)	2
41	Year Entered Program (4 Digit)	4
42	Referring Physician Code	4
43	Reserved for Future Use #1	10
44	Reserved for Future Use #2	1
45	Reserved for Future Use #3	1
46	Reserved for Future Use #4	1

Field Specific Notes...

Sex Code - M-Male, F-Female

Race Code - W-White, B-Black, H-Hispanic, I-American Indian, A-Asian, P-Pacific Islander, E-Middle Eastern, O-Other

Multiracial Flag - 1-Yes, 2-No

Marital Status - S-Single, M-Married, D-Divorced, W-Widowed, P-Separated, 6-Unknown

Occupation - M-Manual, P-Professional, R-Retired, U-Unemployed, D-Disabled, 6-Unknown

Insurance Types (by Position) - 1-Medicaid, 2-Medicare, 3-HMO, 4-BCBS, 5-Other, 6-None. 1 position for each insurance (six total).

Ambulatory Status - O-Outpatient, I-Inpatient, H-Home Health, N-Nursing Home, T-Other

Spoken Language - E-English, S-Spanish, F-French, O-Other

Written Language - E-English, S-Spanish, F-French, O-Other, N-None

Diabetes Type - I-Type 1, N-Type 2, Non Insulin Treated, X-Type 2, Insulin Treated, G-Gestational, D-Difficult to Classify, O-Other, T-Impaired Glucose Tolerance, C-Cystic Fibrosis Related Diabetes, Q-Pre-Diabetes (0-18 yrs), P-Pre-Diabetes (>18yrs).

Height - In Inches.

Weight - In Pounds.

All Dates have separate fields for Month, Day, and Year. The field is blank if no date was entered. The Year Fields are 4 characters long to include the century digits.

Participant Follow Up/Assessment Data File Export

The Diabetes Management System Utilities can generate an export file containing Participant FOLLOW UP assessment data. The default name for this file is PTFEXP.CSV, but the user can change the path/file name just prior to creation of the file during the exportation process.

This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel) that is capable of importing ASCII files. The file layout is listed below **(Note – You must have access rights to the Path and Folder this file is created in).**

FIELD #	DESCRIPTION	LENGTH
1	Last Name	20
2	First Name	20
3	Middle Initial	1
4	Social Security Number	9
5	Medical Record Number	20
6	Month of Assessment (1-12)	2
7	Day of Assessment (1-31)	2
8	Year of Assessment (4 Digit)	4
9	Month of Birth (1-12)	2
10	Day of Birth (1-31)	2
11	Year of Birth (4 Digit)	4
12	Follow Up Status Code (The Follow Up Status Codes are based on the Codes loaded in the System Status File)	3
13	Type of Contact Code (H-Home, O-Office, T-Telephone)	1
14	Change or Loss in Hearing	1
15	Read Newsprint (Vision Changes)	1
16	Normal Sensation to Touch Flag	1
17	Packs Smoked Per Day	1
18	Years Smoked	2
19	Years Since Quit Smoking	2
20	Month Last Seen by Doctor for DM (1-12)	2
21	Day Last Seen by Doctor for DM (1-31)	2
22	Year Last Seen by Doctor for DM (4 Digit)	4
23	Times Hospitalized for Diabetes	2
24	Month Last Hospitalized for DM (1-12)	2
25	Day Last Hospitalized for DM (1-31)	2

26	Year Last Hospitalized for DM (4 Digit)	4
27	Glucose	4
28	Cholesterol	4
29	HDL	4
30	LDL	4
31	Triglycerides	4
32	Creatinine	5
33	Potassium	4
34	Month of Last Urine Microalbumin (1-12)	2
35	Day of Last Urine Microalbumin (1-31)	2
36	Year of Last Urine Microalbumin (4 Digit)	4
37	Microalbumin Negative Flag	1
38	Microalbumin Value	5
39	Weight (lbs)	5
40	Blood Glucose	5
41	Blood Glucose Type	1
42	HBA1c	6
43	Month of HBA1c (1-12)	2
44	Day of HBA1c (1-31)	2
45	Year of HBA1c (4 Digit)	4
46	Liver Function (ALT)	6
47	Liver Function (AST)	6
48	Abdominal Girth	5
49	Height (inches)	6
50	Height (cm)	6
51	Systolic Blood Pressure Value	3
52	Diastolic Blood Pressure Value	3
53	Month of Last B.P. Check (1-12)	2
54	Day of Last B.P. Check (1-31)	2
55	Year of Last B.P. Check (4 Digit)	4
56	Month Last Seen for HTN (1-12)	2
57	Day Last Seen for HTN (1-31)	2
58	Year Last Seen for HTN (4 Digit)	4
59	DM Intervention Flag - Insulin	1
60	DM Intervention Flag - Oral Meds	1
61	DM Intervention Flag - Diet Planning	1
62	DM Intervention Flag - Exercise Planning	1
63	DM Intervention Flag - Glucose Monitoring	1

64	DM Intervention Flag - Insulin Pump	1
65	DM Intervention Flag - No Management	1
66	Reserved for Future Use	1
67	Reserved for Future Use	1
68	Reserved for Future Use	1
69	Month of Last Dietitian Visit (1-12)	2
70	Day of Last Dietitian Visit(1-31)	2
71	Year of Last Dietitian Visit (4 Digit)	4
72	Month of Last Foot Exam (1-12)	2
73	Day of Last Foot Exam (1-31)	2
74	Year of Last Foot Exam (4 Digit)	4
75	Foot Problem Flag - Calluses	1
76	Foot Problem Flag - Deformity	1
77	Foot Problem Flag - Fungal Toenails	1
78	Foot Problem Flag - Neuropathy	1
79	Foot Problem Flag - Ulcer	1
80	Foot Problem Flag - Amputation	1
81	Foot Problem Flag - Bunions	1
82	Foot Problem Flag - None	1
83	Month of Last Dilated Eye Exam	2
84	Day of Last Dilated Eye Exam	2
85	Year of Last Dilated Eye Exam	4
86	Eye Problem Flag - Retinopathy	1
87	Eye Problem Flag - Cataracts	1
88	Eye Problem Flag - Glaucoma	1
89	Eye Problem Flag - Blurred Vision	1
90	Eye Problem Flag - Blindness 1 Eye	1
91	Eye Problem Flag - Blindness 2 Eye	1
92	Eye Problem Flag - None	1
93	# MD Visits in last 12 months	3
94	# RN Visits in last 12 months	3
95	# Hospital Admissions in last 12 months	3
96	Month of Most Recent Hospitalization	2
97	Day of Most Recent Hospitalization	2
98	Year of Most Recent Hospitalization	4
99	Hospital ID Code for Hospitalization	6
100	Primary ICD9 Code	6
101	Month of NEXT Most Recent Hospital.	2

102	Day of NEXT Most Recent Hospital.	2
103	Year of NEXT Most Recent Hospital.	4
104	Hospital ID Code for Hospitalization	6
105	Primary ICD9 Code	6
106	Month of NEXT Most Recent Hospital.	2
107	Day of NEXT Most Recent Hospital.	2
108	Year of NEXT Most Recent Hospital.	4
109	Hospital ID Code for Hospitalization	6
110	Primary ICD9 Code	6

Field Specific Notes...

All Dates have separate fields for Month, Day, and Year. The field is blank if no date was entered.

Foot Problem Flags - 1-True, Blank-False.

Eye Problem Flags - 1-True, Blank-False.

DM Intervention Flags - 1-True, Blank-False.

Participant Billing Data Exportation

The Diabetes Management System Utilities can generate an export file containing Participant MEDICATION data. The default name for this file is BILLEXP.CSV, but the user can change the path/file name just prior to creation of the file. This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel) that is capable of importing ASCII files. The file layout is listed below **(Note – You must have access rights to the Path and Folder this file is created in).**

FIELD	DESCRIPTION	MAX LENGTH
1	Last Name	20
2	First Name	20
3	Medical Record Number	20
4	Internal ID#	20
5	Class ID#	20
6	Class Name/Description	20
7	Attendance Date (MM/DD/YYYY)	10
8	Class Length (in minutes)	10
9	CPT Code	10
10	HCPCS Procedure Code	10
11	Charge Amount	10
13	Frequency	10

Participant Class Attendance Data File Export

The Diabetes Management System Utilities can generate an export file containing Participant Class Attendance data between two dates. The default name for this file is PTCLEXP.CSV, but the user can change the path/file name just prior to creation of the file. This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel) that is capable of importing ASCII files. The file layout is listed below **(Note – You must have access rights to the Path and Folder this file is created in).**

FIELD	DESCRIPTION	MAX LENGTH
1	Attendance Date - Year	4
2	Attendance Date - Mon	2
3	Attendance Date - Day	2
4	Class Title	30
5	Class Length (in minutes)	4
6	Class Method (LEC, DEM, DIS, RTN, VID, OTH, UNK)	3
7	Class Format (CLS, IND, OTH, UNK)	3
8	Instructor's Initials	3
9	Class Location	10
10	Patient Last Name	20
11	Patient First Name	20
12	Patient Middle Initial	1
13	Medical Record Number	15
14	Patient Gender (M, F)	1
15	Patient Date of Birth (MM/DD/YYYY)	10

Participant Gestational Episode Data File Export

The Diabetes Management System Utilities can generate an export file containing Participant Gestational episode data. The default name for this file is GESTEXP.CSV, but the user can change the path/file name just prior to creation of the file. This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel) that is capable of importing ASCII files. The file layout is listed below **(Note – You must have access rights to the Path and Folder this file is created in).**

FIELD#	DESCRIPTION	LENGTH
1	Medical Record Number	15
2	Last Name	20
3	First Name	1
4	Mother's Date of Birth (YYYYMMDD)	15
5	Episode Number	2
6	Number of Fetuses	2
7	Delivery Outcome (N-Normal, C-Caesarian, S-Stillborn, T-Terminated)	2
8	Mother's Normal Weight (lbs)	8
9	Mother's Delivery Weight (lbs)	8
10	Baby #1 Birth Weight (lbs)	8
11	Baby #2 Birth Weight (lbs)	8
12	Baby #3 Birth Weight (lbs)	8
13	Baby #4 Birth Weight (lbs)	8
14	Estimated Gestational Age in Weeks	2
15	GTT Test Date (YYYYMMDD)	15
16	GTT Fasting	5
17	GTT 1 Hour	5
18	GTT 2 Hours	5
19	GTT 3 Hours	5
20	Estimated Delivery Date (YYYYMMDD)	15
21	Actual Delivery Date (YYYYMMDD)	15
22	Number of Pregnancies	2
23	Order of Pregnancy	2

24	Number of Live Births	2
25	Prior Diabetes Diagnosis Type (Description)	20
26	Maternal Hypoglycemia (Y or N)	1
27	Cephalo-Pelvic Diaproportion (Y or N)	1
28	Traumatic Delivery (Y or N)	1
29	Non Elective C-Section (Y or N)	1
30	Macrosomia (Y or N)	1
31	Shoulder Dystocia (Y or N)	1
32	Neonatal Hypoglycemia (Y or N)	1
33	Management Issue – Insulin (1 if TRUE, BLANK if FALSE)	1
34	Management Issue – Oral Meds (1 if TRUE, BLANK if FALSE)	1
35	Management Issue – Diet Planning (1 if TRUE, BLANK if FALSE)	1
33	Management Issue – Exercise Program (1 if TRUE, BLANK if FALSE)	1
33	Management Issue – Glucose Monitoring (1 if TRUE, BLANK if FALSE)	1
33	Management Issue – Insulin Pump (1 if TRUE, BLANK if FALSE)	1
33	Management Issue – None (1 if TRUE, BLANK if FALSE)	1
33	Management Issue (Currently Not Used, Reserved for Future Use)	1
33	Management Issue (Currently Not Used, Reserved for Future Use)	1
33	Management Issue (Currently Not Used, Reserved for Future Use)	1

Billing Data File Export

The Diabetes Management System Utilities can generate an export file containing Class Episode Billing Data. The default name for this file is BILLEXP.CSV, but the user can change the path/file name just prior to creation of the file. Also, the activity date range can be set from the prompt window. This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel) that is capable of importing ASCII files. The file layout is listed below **(Note – You must have access rights to the Path and Folder this file is created in).**

FIELD	DESCRIPTION	MAX LENGTH
1	Patient Last Name	20
2	Patient First Name	20
3	Medical Record Number	15
4	Patient's System Internal ID#	20
5	Class ID #	15
6	Class Title	3
7	Class Date (MM/DD/YYYY)	3
8	Class Length (in minutes)	3
9	CPT Code	10
10	HCPCS Code	20
11	Charge Amount	20

Goal File Data File Export

The Diabetes Management System Utilities can generate an export file containing Patient Goal Data. The default name for this file is GOALEXP.CSV, but the user can change the path/file name just prior to creation of the file. This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel) that is capable of importing ASCII files. The file layout is listed below **(Note – You must have access rights to the Path and Folder this file is created in).**

FIELD	DESCRIPTION	MAX LENGTH
1	Patient Last Name	20
2	Patient First Name	20
3	Patient Middle Name	10
4	Date of Birth (MM/DD/YYYY)	10
5	Diagnosis Type	10
6	Medical Record Number	15
7	Group Filter Code	10
8	Date Goal Set (MM/DD/YYYY)	10
9	Goal Description – Line 1	80
10	Goal Description – Line 2	80
11	Scheduled Date to Meet Goal (MM/DD/YYYY)	10
12	Status of Goal	10
13	Date Goal Met (MM/DD/YYYY)	10
14	Behavioral Group	10
15	Follow Up #1 Date (MM/DD/YYYY)	10
16	Number of Times Met	10
17	Follow Up #2 Date (MM/DD/YYYY)	10
18	Number of Times Met	10
19	Follow Up #3 Date (MM/DD/YYYY)	10
20	Number of Times Met	10
21	Follow Up #4 Date (MM/DD/YYYY)	10
22	Number of Times Met	10
23	How did this affect your Quality of Life?	80
24	What did you learn from this Goal?	80

Patient Medications Data File Export

The Diabetes Management System Utilities can generate an export file containing Patient Medication Data. The default name for this file is MEDSEXP.CSV, but the user can change the path/file name just prior to creation of the file. Also, the activity date range can be set from the prompt window. This file is a comma delineated ASCII file, which can be imported into almost any standard database system (ie, Access, Excel) that is capable of importing ASCII files. The file layout is listed below **(Note – You must have access rights to the Path and Folder this file is created in).**

FIELD	DESCRIPTION	MAX LENGTH
1	Patient Last Name	20
2	Patient First Name	20
3	Patient Middle Initial	1
4	Medical Record Number	15
5	Date of Birth – Month	2
6	Date of Birth – Day	2
7	Date of Birth – Year	4
8	Med Start - Month	2
9	Med Start - Day	2
10	Med Start - Year	4
11	Med ID	10
12	Med Name	30
13	Frequency	10
14	Dose Description	80
15	Route	10
16	Comments	80
17	Ordered By	30
18	DC Date - Month	2
19	DC Date - Day	2
20	DC Date - Year	4

Participant Demographic Data File Importation

The Diabetes Management System Utilities has the capability to import Participant Demographic Data.

This Importation file must be a comma delineated ASCII file, which can be generated by almost, any standard database system (ie, Access, Excel, etc) that is capable of exporting ASCII files. The default import file name is PTINTAKE.CSV. This Importation File must have the following layout...

FIELD #	DESCRIPTION	LENGTH
1	Last Name	20
2	First Name	20
3	Middle Initial	1
4	Social Security Number	9
5	Birth Date - Month Number (1-12)	2
6	Birth Date - Day of Month Number (1-31)	2
7	Birth Date - Year (4 Digit)	4
8	Address - Line 1	30
9	Address - Line 2	30
10	City	20
11	State	2
12	Zip Code	10
13	County Code	3
14	Home Telephone	10
15	Work Telephone	10
16	Sex Code (M-Male, F-Female)	1
17	Race Code W-White, B-Black, I-American Indian, A-Asian, P-Pacific Islander, O-Other	1
18	Multiracial Flag (1-Yes, 2-No)	1
19	Ancestry Code	1
20	Marital Status S-Single, M-Married, D-Divorced, W-Widowed, P-Separated, 6-Unknown)	1
21	Occupation Code M-Manual, P-Professional, R-Retired, U-Unemployed, D-Disabled, 6-Unknown)	1
22	Insurance Code (RESERVED FOR FUTURE USE – LEAVE BLANK)	1
23	Ins. Type #1 (1st Insurance (Default Medicaid), 1 = True; Blank if None)	1
24	Ins. Type #2 (2nd Insurance (Default Medicare), 1 = True; Blank if	1

	None)	
25	Ins. Type #3 (3rd Insurance (Default HMO), 1 = True; Blank if None)	1
26	Ins. Type #4 (4th Insurance (Default BCBS), 1 = True; Blank if None)	1
27	Ins. Type #5 (5th Insurance,(Default Other), 1 = True; Blank if None)	1
28	Ins Type #6 (6th Insurance (Default None), 1 = True; Blank if None)	1
29	Ambulatory Status (O-Outpatient, I-Inpatient, H-Home Health, N-Nursing Home, T-Other)	1
30	Agency Code	4
31	Medical Record Number	20
32	Spoken Language Code (E-English, S-Spanish, F-French, O-Other)	1
33	Written Language Code (E-English, S-Spanish, F-French, O-Other, N-None)	1
34	Years of Schooling	2
35	Highest Degree Attained	4
36	Age at Diagnosis	2
37	Diabetes Diagnosis Type	1
38	Height (In Inches)	5
39	Weight (In Pounds)	5
40	Consent Form Signed	1
41	Month Consent Form Signed (1-12)	2
42	Day Consent Form Signed (1-31)	2
43	Year Consent Form Signed (4 Digit)	4
44	Contact Person Last Name	20
45	Contact Person First Name	20
46	Contact Person Address	20
47	Contact Person City	20
48	Contact Person State	2
49	Contact Person Zip Code	10
50	Contact Person Telephone Number	10
51	Contact Person Relation Code 1-Friend, 2-Neighbor, 3-Relative, 4-Other)	1
52	Referring Physician Code	5
53	Month Entered Program (1-12)	2
54	Day Entered Program (1-31)	2
55	Year Entered Program (4 Digit)	4

Field Specific Notes...

- Sex Code - M-Male, F-Female
- Telephone Numbers - just numbers, do not include any formatting characters.
- Race Code - W-White, B-Black, I-American Indian/Eskimo, A-Asian/Pacific Islander, H-Hispanic, O-Other, E-Middle Eastern.
- Multiracial Flag - 1-Yes, 2-No
- Ancestry Code - E-European, A-African, H-Hispanic, I-American Indian, B-Arab, S-Asian, F-Finnish, O-Other
- Marital Status - S-Single, M-Married, D-Divorced, W-Widowed, P-Separated, 6-Unknown
- Occupation - M-Manual, P-Professional, R-Retired, U-Unemployed, D-Disabled, 6-Unknown
- Insurance Types - 1-Medicaid, 2-Medicare, 3-HMO, 4-BCBS, 5-Other, 6-None
- Ambulatory Status - O-Outpatient, H-Home Health, N-Nursing Home, T-Other
- Spoken Language - E-English, S-Spanish, F-French, O-Other
- Written Language - E-English, S-Spanish, F-French, O-Other, N-None
- Diabetes Diagnosis Type - I-Type 1, N-Type 2 (non insulin treated), X-Type 2 (insulin treated), G-Gestational, D-Difficult to Classify, O-Other, T-Impaired Glucose Tolerance, C-CFRD, Q-Pre-Diabetes (0-18yrs), P-Pre-Diabetes (> 18yrs).
- All Dates have separate fields for Month, Day, and Year. The field is blank if no date was entered.
- The Year Fields are 4 characters long to include the century digits.
- Contact Person Relation Code - 1-Friend, 2-Neighbor, 3-Relative, 4-Other.

The "Date Entered Program" (Month, Day, Year) Fields #53, #54, #55. If these fields are left blank, the importation process will put in the current System Date. Regardless, this date will never be left blank in the patient demographic record after importation. The reason is that almost all the reports are based (and filtered) on this date. We suggest putting in a date of 1/1/1990 for this date. That way, the users can easily filter on

this date and print a report on all the imported patient records who need to have there data completed and their correct program entry date entered.

Participant Lab Data File Importation

The Diabetes Management System Utilities has the capability to import Participant Lab Data.

This Importation file must be a comma delineated ASCII file, which can be generated by almost, any standard database system (ie, Access, Excel, etc) that is capable of exporting ASCII files. The default import file name is PTLABS.TXT. This Importation File must have the following layout...

FIELD #	DESCRIPTION	LENGTH
1	Medical Record Number	15
2	Month of Lab Work (2 digits)	2
3	Day of Lab Work (2 digits)	2
4	Year of Lab Work (4 digits)	4
5	Cholesterol	10
6	HDL	10
7	LDL	10
8	Triglycerides	10
9	Creatinine	10
10	Potassium	10
11	Liver Function (ALT)	10
12	Liver Function (AST)	10
13	Month of Urine Microalbumin (2 digits)	2
14	Day of Urine Microalbumin (2 digits)	2
15	Year of Urine Microalbumin (4 digits)	4
16	Microalbumin Negative (1=Neg., 0=Pos)	1
17	Microabumin Result	10
18	Height in Inches	7
19	Height in Centimeters	7
20	Weight in Pounds	10
21	Weight in Kilograms	10
22	Abdominal Girth	5
23	Blood Glucose	10
24	Glucose Type (1=FBS, 2=Pre-Meal, 3=PP, 0=Unknown)	1

25	Self Monitoring of Blood Glucose (0=No, 1=Yes)	1
26	HBA1c	8
27	Month of HBA1c (2 digits)	2
28	Day of HBA1c (2 digits)	2
29	Year of HBA1c (4 digits)	4
30	Ketones (0=Nie, 1=Trace, 2=Small, 3=Moderate, 4=Large, 5=Not Tested)	1
31	TSH (Thyroid Stimulating Hormone)	10

Note – Only NEW Assessment Records will be added during the importation process. If the participant already has an Assessment Record with the same date as the Import Record, the Import Record will not be imported into the System.

Physician Data File Importation

The Diabetes Management System Utilities has the capability to import Physician Data.

This Importation file must be a comma delineated ASCII file, which can be generated by almost, any standard database system (ie, Access, Excel, etc) that is capable of exporting ASCII files. The default import file name is DRINTAKE.CSV. This Importation File must have the following layout...

FIELD #	DESCRIPTION	LENGTH
1	Physician ID Number	6
2	Last Name	20
3	First Name	20
4	Middle Initial	1
5	Institution Name	35
6	Address – Line 1	30
7	Address – Line 2	30
8	City	20
9	State	2
10	Zip Code	10
11	Work Telephone (no formatting characters)	10
12	Home Telephone (no formatting characters)	10
13	Fax Telephone (no formatting characters)	10
14	Office Contact Person Name	20
15	Specialty	20
16	UPIN or NPI#	20

Note – Only NEW Physician records will be added (based upon Physician ID Number).

PRAXIS Scheduler Data Importation

The Diabetes Management System Utilities has the capability to import Participant data from the PRAXIS Scheduler System.

This Importation file must be a comma delineated ASCII file, which is generated by the PRAXIS Scheduler. The default import file name is PIMPORT.CSV. This Importation File must have the following layout...

FIELD #	DESCRIPTION	LENGTH
1	Participant ID (Med Rec #)	12
2	Last Name	20
3	First Name	20
4	Middle Initial	1
5	Sex Code (M, F)	1
6	Birth Date (MM/DD/YYYY)	10
	Service Date (MM/DD/YYYY)	10
8	Social Security No. (XXX-XX-XXXX)	11
9	Street Address	30
10	City	20
11	State	2
12	Zip Code	10
13	Day Telephone (XXX-XXX-XXXX)	12
14	Home Telephone (XXX-XX-XXXX)	12
Fields # 15 to 23 Below Are Not Imported...		
15	Referring Physician	40
16	Responsible Relative	40
17	Relation	8
18	Insurance	10
19	Group	10
20	Insurance Phone	10
21	Comments #1	20
22	Comments #2	20
23	Primary Physician	20

HL7 Interface Engine, An Introduction.

The Diabetes Management System has a stand-alone HL7 Interface Engine. The application is located in the Diabetes Mgmt System program folder and is named DMSHL7.EXE.

- The Engine uses the HL7 v2.x standard.
- The Engine can import patient demographic and lab data using the PID, PV1, NK1, and OBX message segments.
- The Engine can export Diabetes Mgmt System generated data into HL7 format for use in other systems. The following data can be exported into HL7 formats:
    - Patient Demographics (using the PID, PV1, NK1, and OBX segments).
    - Clinical Values from Assessment Visits (using OBX segments).
    - Narrative and SOAP Notes (using NTE segments).
    - Educational Records (using NTE segments).
    - Educational Assessment Records (using NTE segments).
    - Goal Status Records (using NTE segments).
    - Medication Records (using NTE segments).

Setting Up the HL7 Engine

Shortcuts to the Engine should only be set up on the workstations that need to run the Engine. Setting up the Engine just is a matter of mapping the drive and folder where the Diabetes Mgmt System resides (if it is not mapped already), and setting up a shortcut to the HL7Engine application, DMSHL7.EXE.

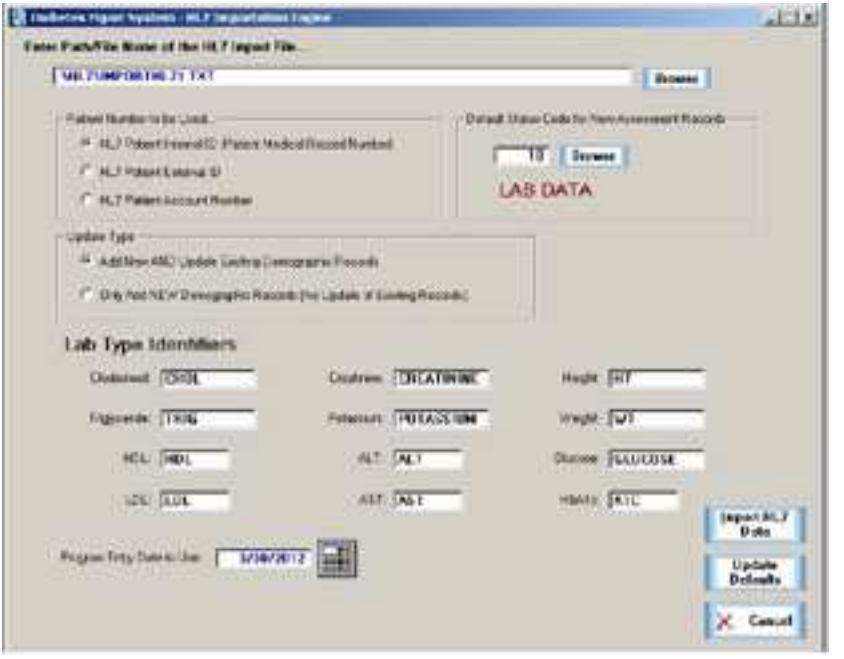
Starting the HL7 Engine.

The HL7 Engine is password protected. Only users with administrative access to the Diabetes Management System. Users can only be maintained with the main Diabetes Mgmt System.

The HL7 Interface Engine Log In Window

The HL7 Interface Engine Main Window.

HL7 Importation



The HL7 Interface Engine Importation Window.

Importation Window Options

Path/File Name of the Importation File: Enter the complete path and file name of the file containing the HL7 importation data. You can use the Browse button to navigate folder quickly.

Patient Number to be Used: The HL7 standard PID segment has three different fields that can contain a patient number and you can choose which one to use for the Medical Record Number during importation. The default (and normal) field is the first choice; the HL7 Internal ID.

Default Status Code for New Assessment Records: If new Assessment Records are imported into the System, this Status Code (Assessment Visit Type) will be used for these records.

Update Type: You can choose the update type of importation records...

- Add New and Update Existing Records.
- Add Only New Records (no updates).

Lab Type Identifiers: This section contains all the lab values that can be imported by the Engine. Enter the lab text your importation file contains for that particular lab type. The Engine uses these value labels to identify the various values.

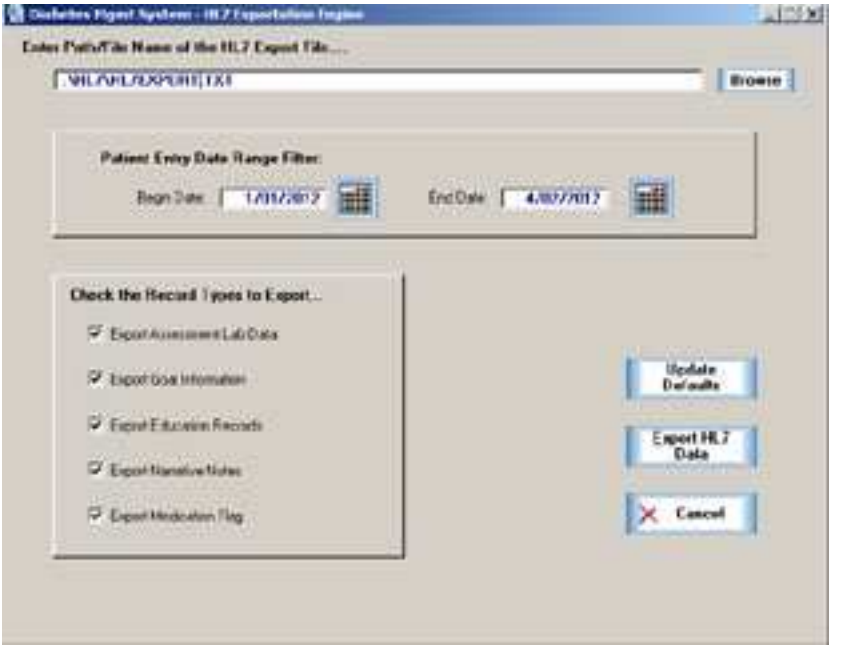
Program Entry Date: This is the date the Engine will use to use for "Program Entry Date" for new imported demographic records.

Import Button: Starts the Importation Process.

Update Defaults Button: Saves your values on this window as the system default values.

Cancel Button: Cancels this procedure and closes the window.

HL7 Exportation



The HL7 Interface Engine Exportation Window.

Exportation Window Options

Path/File Name of the Export File: Enter the complete path and file name of the file where you wish to export your exported HL7 data to. You can use the Browse button to navigate folder quickly.

Export Type Options: The Export will automatically, at a minimum, the patient demographic data. This section allows you to select which record types, beyond the demographics, you wish to export. All the record types are set to export, by default. Uncheck the record types you wish to suppress exportation.

Update Defaults Button: Saves your Exportation Path/File Name as the system export default value.

Export HL7 Data Button: Begins the HL7 Process.

Cancel Button: Cancels the Exportation and Closes this window.

Generated HL7 Export File Record Details

MSH Segment (Message Header)

The MSH segment is required for all messages and will always be the first segment in the message

Sample Generated MSH Segment:

MSH|^~\&|HarborDMS||HarborDMS||20120327101102||ADT^A08|HSI4977077|P|2.3|||||

All generated Export files will have a ADT^A08 message type, Patient Update.

PID Segment (Patient Identification)

The PID segment contains information about the patient, and is used to export demographic data fields from the Diabetes Mgmt System.

Sample Generate d MSH Segment:

PID||00 J111|200705171051038||JOHNSON^JACK^BENJAMIN^||19461115|M||W|115 WILLSTOM ST.^^PETOSKEY^MI^32174||2313478866|2313479473|E|M|||||||||||||

PV1 Segment (Patient Visit Information)

The PV1 segment is used to contain additional information about the patient. The HL7 Engine uses this record to export info about the patient's referring physician.

Sample Generate d MSH Segment:

PV1|0001|DMS|R||||1^HALLAH, MD KATHLEEN L|||||||||||||||||||||||||||||||||200702050800 |||||||0000000.00|0000000.00

NK1 Segment (Next of Kin Information)

The NK1 Segment is used to export the patient's Contact Person information. If the patient has two contacts in their demographic record, two NK1 segments are generated.

Sample Generate d NK1 Segment:

NK1|0001|CANDY JOHNSON||115 WILLSTOM ST.^PETOSKEY^MI^32174|(231)347-8866

OBX Segment (Observation Information)

The OBX Segment is used to export one patient observation per record. The Engine generates OBX segments for Barriers to Learning and for Clinical Assessment Values.

Sample Generate d OBX Segment for a Barrier to Learning

OBX|001|ST|Learning Barrier||VISUALLY IMPAIRED|||||||20070102

Sample Generate d OBX Segments for Clinical Lab Value

OBX|002|NM|CHOLESTEROL (MG)|| 180|||||||20070102

OBX|003|NM|HDL (MG/DL)|| 55|||||||20070102

OBX|004|NM|LDL (MG/DL)|| 90|||||||20070102

OBX|055|NM|HbA1c (%)|| 7.0|||||||20070312

OBX|057|NM|BLOOD PRESSURE||118/ 70|||||||20070312

NTE Segment (Notes and Comments)

The NTE Segment is used to export several types of patient records; Narrative Notes, SOAP Notes, Educational Records, Educational Assessment Records, Goals, and Medications.

Sample Generate d NTE Segments for Narrative Notes

NTE|1|Nar Note^(Note Date)20070205^(Signer)Susan Hemme, RN^(Record ID)3663473

NTE|2|Patient came with wife. Both very apprehensive and worried. Wife will be involved in care. Patient willing to "work hard" at controlling blood sugar for his wife. Right now patient refuses to do his own testing. Wife will do it and come to all classes with patient. SH

NTE Segments for Narratives contain two records for each narrative. Line #1 contains general note information with each field identified within parenthesis. Line #2 contains the body of the note.

Sample Generate d NTE Segments for SOAP Notes

NTE|1|SOAP Note^(Note Date)20070305^(Signer)Debra King^(Record ID)4268540

NTE|2|SUBJECTIVE^I don't want to alter my life. I don't think I can do my own blood sugars

NTE|3|OBJECTIVE^Patient has reservations about new diagnosis. Seems embarrassed for his friends and family to know.

NTE|4|ASSESSMENT^Wife is supportive and willing to help while patient gets used to new diagnosis

NTE|5|PLAN^wife to come to all education. Pt willing to go through complete education

NTE Segments for SOAP Notes contain five records for each SOAP. Line #1 contains general note information with each field identified within parenthesis. Line #2 contains the Subjective data, Line #3 contains the Objective data, Line #4 Assessment data, and Line #5, the Plan.

Sample Generate d NTE Segments for Educational Records

NTE|001|Ed Rcd^(Class Date)20070205^(Class)INITIAL INTERVIEW^(Minutes)60 ^(Instructor Initials)SH

NTE|002|Ed Rcd^(Class Date)20070319^(Class)SESSION 1^(Minutes)180^(Instructor Initials)DK

NTE Segments for Educational Records contain one record for each exported record, each field identified within the parenthesis.

Sample Generate d NTE Segments for Educational Assessment Records

NTE|001|Ed Assess^(Content Area)PREVENTING, DETECTING, AND TREATING ACUTE COMPLICATIONS^(PrePgm Assess Date)20070205^(PrePgm Initials)SH^(PrePgm Knowledge)0^(Date Taught)20070409^(PostPgm Assess Date)20070518^(PostPgm Initials)SH^(PostPgm Knowledge)1^(Reinforcement Date)^(Signatures)

NTE|002|Ed Assess^(Content Area)PREVENTING, DETECTING, AND TREATING CHRONIC COMPLICATIONS^(PrePgm Assess Date)20070205^(PrePgm Initials)SH^(PrePgm Knowledge)0^(Date Taught)20070409^(PostPgm Assess Date)20070518^(PostPgm Initials)SH^(PostPgm Knowledge)1^(Reinforcement Date)^(Signatures)

NTE Segments for Educational Assessment Records contain one record for each exported Educational Assessment record, each field identified within the parenthesis.

Sample Generate d NTE Segments for Goal Records

NTE|003|Goal Rcd^(Desc)I WILL EXAMINE MY FEET EVERY DAY. ^(BehavGrp)REDUCING STRESS^(Set Dte)20070205^(Sch Dte)20070319^(Met Dte)20070628^(Acheive)100^(FU1)^(FU1%)90^(FU2)^(FU2%)0^(FU3)^(FU3%)0^(FU4)^(FU4%)0^REDUCE RISK OF FOOT-RELATED COMPLICATIONS^NOT A HARD GOAL TO MEET, I CHECK FEET AFTER SHOWER

NTE Segments for Goal Records contain one record for each exported Patient Goal, each field identified within the parenthesis.

Sample Generate d NTE Segments for Medication Records

NTE|001|Meds^ WELLBUTRIN^(Dose)100MG BID^(Ord By) LOOM P.A.-C^(Start Dte)20060518^(DC Dte)20060518^(Cmts)STATES IT HAS HELPED HER "KEEP ON TASK"

NTE|002|Meds^ LANTUS^(Dose)44 UNITS PM DAILY^(Ord By) HALLAH, MD^(Start Dte)20061116^(DC Dte)20061116^(Cmts)SKIPS EVENING SLIDING SCALE

NTE Segments for Medication Records contain one record for each exported Patient Medication, each field identified within the parenthesis.

Audit Activity File.

The Engine records activity with the interface to a text file named HAUDIT.TXT located in the HL7 folder beneath the DMS program folder.

FORMULAS USED

IDEAL BODY WEIGHT (IBW)

FOR MEN: IBW = 50 + ((HEIGHT - 60) * 2.3)

For Height less than 60 inches tall, use 50 kg.

FOR WOMEN: IBW = 45.5 + ((HEIGHT - 60) * 2.3)

For Height less than 60 inches tall, use 45.5 kg.

BODY MASS INDEX (BMI)

BMI = Weight (kg) / (Height (meters) * Height (meters))
Guidelines...
BMI > 22 - at risk for Diabetes
BMI > 27 - overweight
BMI > 30 – obese

CALORIE NEED CALCULATOR (Mifflin-St. Jeor Equation)

For Women...

REE* = 10(kg) + 6.25(cm) – 5(age) -161

For Men...

REE* = 10(kg) + 6.25(cm) – 5(age) + 5

Calculated Calorie Need = REE * Activity Factor of 1.3 or 1.4 or 1.5

*REE = Resting Energy Expenditure

ESTIMATED AVERAGE GLUCOSE

eAG = 28.7 × A1c − 46.7

Troubleshooting

You are welcome to call Harbor any time for help with questions. Listed below are some common questions we receive...

Problem: **Lost / Forgotten Password.**

Solution: Have another user who has Administrator Access, log into the System and click on FILE > USERS. They can update your password from there.

Problem: **Update did not work.**

Solution: Make sure all users are completely out of the Diabetes Management System before performing the upgrade. A common (and easy) method is to rename the main application (DMS.EXE). If you cannot successfully rename it, someone has the system running.

Problem: **System stops with an Error Message Displayed.**

Solution: Write down the complete Error Message that is displayed and contact Harbor.

Problem: **A report does not display any information.**

Solution: Many reports are based on a date range. Be sure the date range is correct and try again. Otherwise call Harbor.

Problem: **Patients are displayed on one workstation, but not on another.**

Solution: Verify that the two workstations are accessing the same data folder. Otherwise, call Harbor.

Problem: **I expected more patients to be listed on my Outcomes Report.**

Solution: An outcome measures change over time, so a minimum of two values are required. The System only displays patients with two or more outcome values.

For More Information

Our staff can be reached at any of the following numbers for more information...

Voice: (231) 347-8866 (between 9a-5p EST, Monday through Friday).

Fax: (231) 347-9473

E-mail: info@harborsoft.com

Web Site: http://www.harborsoft.com

User Support Page...

Harbor Software has a user support page for Diabetes Mgmt System Users, located here...

http://www.harborsoft.com/

.. Click on "**Diabetes Mgmt**", then "**Support**". System news, Upgrade Information / Download Links, and Documentation can be found here.

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